MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH 17000

County Allegany

Village of City Cumberland (No. T. B. Hos St.; Ward)

Outside of City Limits.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Williams Adams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH — (Month) — (Day) 1883 (Year)

7 AGE About 32 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry business, or establishment in which employed (or employer):

328

PARENTS

9 BIRTHPLACE (State or country): Oklahoma

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Cooper Supt. T.B. Hos

(Address) Cumberland Md

15 Filed OCT 6 1915, 191 Max Hurter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 5, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1915, to Oct 6, 1915, that I last saw h alive on Sept 3, 1915, and that death occurred on the date stated above, at 9 m.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) W. L. Wade, M. D.

Oct 6 191 5 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 3 mos. ds. In the State, yrs. 3 mos. ds.

Where was disease contracted, if not at place of death? Carlisle, Pa.

Former or usual residence Oklahoma

19 PLACE OF BURIAL OR REMOVAL: St. Peter & Paul — OATE OF BURIAL: Oct 7, 1915

20 UNDERTAKER: Gans & Stein — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 10

17001

104

1 PLACE OF DEATH

County Allegany

Village or City Mt Savage (No. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William S. Aldridge

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: August (Month) 8 (Day), 1915 (Year)

7 AGE: ..... yrs. 2 mos. 2 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Robt Aldridge

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Helen P. Logue

13 BIRTHPLACE OF MOTHER (State or country): Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R W Aldridge

(Address) Mt Savage Md

15 Filed Oct 11 1915 F A Kumray Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Octob (Month) 10 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1915, to Oct 10, 1915, that I last saw h— alive on Oct 9, 1915, and that death occurred on the date stated above, at 4 a m.

The CAUSE OF DEATH * was as follows:

Acute Gastro Enteritis

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory .....
Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F Allan Kumray, M. D.

Oct 11, 1915 (Address) Mt Savage Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mt Savage Md — DATE OF BURIAL: Oct 13, 1915

20 UNDERTAKER: J J Hurst — ADDRESS: Frostburg Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 8

17002

(5)

[1] PLACE OF DEATH

County Allegany

Village or City Lonaconing (No. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

[2] FULL NAME (Stillborn) Anderson

PERSONAL AND STATISTICAL PARTICULARS

[3] SEX: Indeterminate

[4] COLOR OR RACE: White

[5] SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): —

[6] DATE OF BIRTH: Oct 27th, 1915
(Month) (Day) (Year)

[7] AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min. ?

[8] OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

[9] BIRTHPLACE (State or country): Maryland

PARENTS

[10] NAME OF FATHER: John Anderson

[11] BIRTHPLACE OF FATHER (State or country): Maryland

[12] MAIDEN NAME OF MOTHER: Myrtle Detter

[13] BIRTHPLACE OF MOTHER (State or country): Maryland

[14] THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John Anderson

(Address) Lonaconing,

[15] Filed Oct 27, 1915 J. O. Bullock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

[16] DATE OF DEATH: ....., 191....
(Month) (Day) (Year)

[17] I HEREBY CERTIFY, That I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Abortion at 2½ months,

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory
Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Billing, M. D.

Oct 27th, 1915. (Address) Lonaconing

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

[18] LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death?

Former or usual residence

[19] PLACE OF BURIAL OR REMOVAL: Annandale

DATE OF BURIAL: ....., 191....

[20] UNDERTAKER

ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

17003

Registration Dist. No. 4

(5) Outside of City Limits.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH
County Allegany
Village of ~~City~~ Dickens, Md (No. , St.; Ward)

2 FULL NAME Still Premature Birth, Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Not known
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Not known (Month) (Day) , (Year)

7 AGE: Foetus probably 2 mo yrs. mos. ds.
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Dickens Md

PARENTS

10 NAME OF FATHER: King Anderson
11 BIRTHPLACE OF FATHER (State or country): Md
12 MAIDEN NAME OF MOTHER: Jessie Dickens
13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEOGE
(Informant) Jessie Anderson
(Address) Dickens Md

15 Filed OCT 19 1915, 191 Mal Sutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 16 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..., 191..., to ..., 191..., that I last saw h... alive on ..., 191..., and that death occurred on the date stated above, at ... m.

The CAUSE OF DEATH * was as follows:

Removed the products of conception probably two months duration (Duration) yrs. mes. ds.

Contributory Secondary

(Ouration) yrs. mes. ds.

(Signed) M. F. Lee M. D.
Oct 18, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mes. ... ds. In the State, ... yrs. ... mes. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lot
DATE OF BURIAL: 10/19, 1915

20 ~~UNDERTAKER~~: King Anderson
ADDRESS: Dickens, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 7

17004

(104)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Maccarb Mills (No. ....., ... St.; ..... Ward)

2 FULL NAME Celestine Ayers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): M

6 DATE OF BIRTH: Aug (Month) 18 (Day), 1914 (Year)

7 AGE: 1 yrs. 1 mos. 16 ds. | If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: V
(b) General nature of industry, business, or establishment in which employed (or employer): V

9 BIRTHPLACE (State or country): Allegany Co Md

PARENTS

10 NAME OF FATHER: Ezekiel Ayers

11 BIRTHPLACE OF FATHER (State or country): Allegany Co Md

12 MAIDEN NAME OF MOTHER: Lucy Hyde

13 BIRTHPLACE OF MOTHER (State or country): Alleg. Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ezekiel Ayers

(Address) Maccarb Mills

15 Filed Oct 4th, 1915 S. A. Boucher
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 4th (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,

that I last saw h.er alive on Oct 4, 1915

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) Several days yrs. ..... mos. ..... ds.

Contributory
Secondary
Convulsions (Duration) about one hour yrs. ..... mos. ..... ds.

(Signed) S. A. Boucher, M. D.

Oct 4, 1915 (Address) Barton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Hill Cemetery | DATE OF BURIAL: Oct 5, 1915

20 UNDERTAKER: D. S. Boal | ADDRESS: Barton

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accidental; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17005

County Allegany

Village or City Cumberland (No. 25 N. Mech. St.; Ward)

2 FULL NAME Annie M. Bachman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May 21, 1849 (Month) (Day) (Year)

7 AGE: 66 yrs. 4 mos. 29 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry business, or establishment in which employed (or employer): at Large

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: John H Zink

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Mary Herbig

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Charles Sommers

(Address) Emmitsburg

15 Filed OCT 21 1915, 191 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 20, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 191, to Oct 191, that I last saw h[illegible] alive on 191, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Chronic Organic Heart Disease

Sudden death in bed

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Thos. H. Lord M. D.

Oct. 21, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Ger Lutheran Cem. DATE OF BURIAL: Oct. 21, 1915

20 UNDERTAKER: Louis Stein ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

17006

(1)

1 PLACE OF DEATH

County Allegany

Village or City Cumb'd (No. West Md Hosp. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Louis Vincent Bachman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Dec 8, 1894 (Month, Day, Year)

7 AGE: 20 yrs. 9 mos. 28 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry business, or establishment in which employed (or employer): Gen'ral

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: John Bachman

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie E Raley

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A Bachman

(Address) Cumberland

15 Filed OCT 7 1915, 191 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 6, 1915 (Month, Day, Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1915, to Oct 6, 1915; that I last saw him alive on Oct 5, 1915; and that death occurred on the date stated above, at 5 a m.

The CAUSE OF DEATH * was as follows:

Typhoid Fever —

(Duration) 0 yrs. 0 mos. 10 ds.

Contributory Secondary —

(Duration) yrs. mos. ds.

(Signed) W. F. Tevis, M. D.

Oct 7, 1915 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. 1 ds. In the State, 20 yrs. 9 mos. 28 ds.

Where was disease contracted, if not at place of death? Cumberland, Md

Former or usual residence Cumberland, Md.

19 PLACE OF BURIAL OR REMOVAL: Lemon Luthn

DATE OF BURIAL: Oct 8, 1915

20 UNDERTAKER: Louis Stein

ADDRESS: Cumb'd

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

17007

64

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH
County Allegany
Village or City Frostburg (No. ....., ... St.; ..... Ward)

2 FULL NAME Samuel Adam Baer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Nov. 28, 1846 (Month) (Day) (Year)

7 AGE: 68 yrs. 10 mos. 25 ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Educator
(b) General nature of industry, business, or establishment in which employed (or employer): Normal School

9 BIRTHPLACE (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: John Baer
11 BIRTHPLACE OF FATHER (State or country): Pennsylvania
12 MAIDEN NAME OF MOTHER: Marie Adam
13 BIRTHPLACE OF MOTHER (State or country): Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S. A. Baer
(Address) Frostburg, Md.

15 Filed Oct 24, 1915 D. L. Conrey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 22, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1915, to Oct. 22, 1915, that I last saw h.... alive on Oct. 22, 1915 and that death occurred on the date stated above, at 5 45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory
Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. R. Walker, M. D.
Oct 23, 1915 (Address) Frostburg Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Reading, Pa. DATE OF BURIAL: Oct. 25, 1915

20 UNDERTAKER: Jacob Baer ADDRESS: Frostburg, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., requesting V. S. No. 1.

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17008

County Allegany

Village or City Cumberland (No. 36, Bellvue St.; Ward)

2 FULL NAME Charles Edw Bageut

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Mar 11 (Month), 1915 (Day), (Year)

7 AGE: — yrs. 6 mos. 27 ds.

If LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Chas. O. Bageut.

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Clara Paul.

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. O. Bageut

(Address) 36 Bellvue St

15 Filed OCT 9 1915, 191 — Wm. Hutton, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 7 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1915, to Oct 7, 1915, that I last saw him alive on Oct 7, 1915, and that death occurred on the date stated above, at 11 a. m.

The CAUSE OF DEATH * was as follows:

Gastroenteritis

(Duration) ... yrs. ... mos. ... ds.

Contributory Secondary

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. A. Prevaske's, M. D.

Oct 9, 191 5 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Geo. Lyle Cem. DATE OF BURIAL: Oct 9, 1915

20 UNDERTAKER: Louis Stein ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH 17069

STATE OF MARYLAND
CERTIFICATE OF DEATH

County Allegany

Registration Dist. No. 10

Village or City Mt Savage (No. ...., ... St.; .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Michael E. Birmingham

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: Male; 4 COLOR OR RACE: White; 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single	16 DATE OF DEATH: Oct (Month) 3 (Day), 1915 (Year)
6 DATE OF BIRTH: Jan (Month) 26 (Day), 1873 (Year)	17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1915, to Oct 3, 1915, that I last saw him alive on Oct 2, 1915, and that death occurred on the date stated above, at 4 a.m.
7 AGE: 42 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or ...min.?	The CAUSE OF DEATH * was as follows: Angina Pectoris (Duration) ....yrs. ....mos. ....ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work: Laborer; (b) General nature of industry business, or establishment in which employed (or employer): —	Contributory (Secondary): Myocarditis (Duration) ....yrs. 3 mos. ....ds.
9 BIRTHPLACE (State or country): Md	(Signed) F. Alan G. Murray, M.D. Oct 4, 1915 (Address) Mt Savage Md
PARENTS: 10 NAME OF FATHER: James Birmingham	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
11 BIRTHPLACE OF FATHER (State or country): Ireland	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
12 MAIDEN NAME OF MOTHER: Agnes McMahon	Where was disease contracted, if not at place of death?
13 BIRTHPLACE OF MOTHER (State or country): N.Y. State	Former or usual residence
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Thos Birmingham (Address) Mt Savage Md	19 PLACE OF BURIAL OR REMOVAL: Mt Savage; DATE OF BURIAL: Oct 5, 1915
15 Filed Oct 4, 1915 F. Fitzgerald, Registrar	20 UNDERTAKER: J. J. Durst; ADDRESS: Fbg Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day labarer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Branchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbalic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. X

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH — 17010 — (144)

County Allegany

Village or City Cumberland (No. West Md Hosp St.; Ward)

2 FULL NAME Nellie May Blaker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: April 15 (Month), (Day), 1891 (Year)

7 AGE: 24 yrs. 5 mos. 28 ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer): at Home

9 BIRTHPLACE (State or country): West Va

PARENTS

10 NAME OF FATHER: Daniel Twigg

11 BIRTHPLACE OF FATHER (State or country): West Va

12 MAIDEN NAME OF MOTHER: Mary Millison

13 BIRTHPLACE OF MOTHER (State or country): West Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Blaker

(Address) Ridgely West Va

15 Filed OCT 15 1915, 191 ..... Ma Sutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 13 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1915, to Oct. 12, 1915, that I last saw her alive on Oct. 12, 191 , and that death occurred on the date stated above, at 9:20 a m.

The CAUSE OF DEATH * was as follows:

Cellulitis of face and scalp.

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory Secondary: Septicemia

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) J. K. Cardwell, M. D.

Oct. 14, 191 (Address) Ridgely W. Va

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. 1 ds. In the State, ... yrs. ..... mos. 1 ds.

Where was disease contracted, if not at place of death? Ridgely West Va

Former or usual residence Ridgely West Va

19 PLACE OF BURIAL OR REMOVAL: Rosehill Cem — DATE OF BURIAL: Oct 15, 1915

20 UNDERTAKER: Louis Stein — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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17011

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. W. Md Hospital St.; Ward)

2 FULL NAME William Carl Blaine

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH: July (Month) 17 (Day), 1875 (Year)

7 AGE: 40 yrs. 2 mos. 25 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Butcher
(b) General nature of industry business, or establishment in which employed (or employer): Store.

65

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Frank A Blaine

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Elizabeth Snyder

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Clifton White

(Address) Cumberland Md

15 Filed OCT 15 1915, 191 Max Sutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 12 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1915, to Oct 12, 1915, that I last saw h[illegible] alive on Oct 12, 1915, and that death occurred on the date stated above, at 12 P. m.

The CAUSE OF DEATH * was as follows:

Carcinoma of Rectum

(Duration) yrs. 9 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) D A H Hawkins, M. D.

Oct 14, 1915 (Address) Cumberland, Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 2 mos. ds. In the State, 40 yrs. 2 mos. 25 ds.

Where was disease contracted, if not at place of death? Cumberland, Md

Former or usual residence Cumberland Md.

19 PLACE OF BURIAL OR REMOVAL: Ger Luth Cem — DATE OF BURIAL: Oct 15, 1915

20 UNDERTAKER: Louis Stein — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17012

County Allegany

Village or City Cumberland (No. R.F.D #2 St.; Ward)

2 FULL NAME Mrs Charley A Blubaugh

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	married

6 DATE OF BIRTH Feb (Month) 2 (Day) 1866 (Year)

7 AGE 49 yrs. 8 mos. — ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Lancaster

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Bree McKinney

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charley A Blubaugh

(Address) R.F.D #2 Cumberland

15 Filed Oct 4, 191 D. Bennett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 2 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1915, to Oct 2, 1915, that I last saw her alive on Oct 2, 1915, and that death occurred on the date stated above, at 10 3/4 m.

The CAUSE OF DEATH * was as follows:

Typhoid Fever

(Duration) yrs. 1 mos. 4 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) A. P. Twigg, M. D.

Oct 2, 1915 (Address) Flintstone Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pleasant Grove	Oct 4, 1915
20 UNDERTAKER	ADDRESS
John C Wolford	Cumberland

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory.". (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

17013

(624)

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. 349 Bedford St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME A J Braut

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Feby 26, 1826 (Month, Day, Year)

7 AGE: 89 yrs. 7 mos. 14 ds.

If LESS than 1 day, hrs. OR mins.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Penn.

PARENTS

10 NAME OF FATHER: Henry Braut.

11 BIRTHPLACE OF FATHER (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter W Braut

(Address) 349 Bedford St.

15 Filed OCT 11 1915

Ida Holton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Oct 10, 1915 (Month, Day, Year)

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1915, to Oct 10, 1915, that I last saw him alive on May 8, 1915, and that death occurred on the date stated above, at 12 o'c m.

The CAUSE OF DEATH * was as follows:

Apoplexy —

Cerebral Hem. (Duration) 0 yrs. 0 mos. 0 ds.

Contributory Secondary: Senility and

General Weakness (Duration) Several yrs. 0 mos. 0 ds.

(Signed) Dr. T. Brace, M. D.

Oct 11, 1915 (Address) Cumb Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Wilson Cem Alleg Co. DATE OF BURIAL: Oct. 12, 1915

20 UNDERTAKER: Louis Stein ADDRESS: City.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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S. Lowe Victoria Ann
Peter Amanda Hicks
Leonard Josie Forbes
Grant Mt Lauzon
Theo
D. F. 1914 Oct sick.

Volunteered Penn'a. 7. 1861 9th
wounded.
Gettysburg
Bull Run
Antietam
Chancellorsville
7 days
Wilderness

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

17014

(9)

Registration Dist. No. 4

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. 11 Rolling Mill Alley St., Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME ~~[illegible]~~ Brown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colord

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct (Month) 5 (Day), 1915 (Year)

7 AGE: — yrs. — mos. — ds. If LESS than 1 day, ... hrs. OR ...... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Burrel Brown

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Lillie Maigo

13 BIRTHPLACE OF MOTHER (State or country): Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Burrel Brown

(Address) 11 Rolling Mill Alley

15 Filed OCT 6 1915, 191 Max [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 5th (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from —, 191 , to —, 191 ,

that I last saw h— alive on —, 191 ,

and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) ...... yrs. ...... mos. ...... ds.

Contributory
Secondary

(Duration) ...... yrs. ...... mos. ...... ds.

(Signed) [illegible], M. D.

Oct. 6, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ...... yrs. ...... mos. ...... ds. In the State, ... yrs. ...... mos. ...... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Sumner Cem

DATE OF BURIAL: 10/6, 1915

20 UNDERTAKER: Louis Stein

ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

17015

(97)

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Allegany

Registration Dist. No. 4

Village or City Cumberland (No. 146 Fredrick St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Samuel M Burgee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Aug (Month) 29 (Day), 1866 (Year)

7 AGE 49 yrs. 1 mos. 16 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Janitor

(b) General nature of industry business, or establishment in which employed (or employer)

932

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Fredrick Burgee

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Brown

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fredrick Burgee

(Address) 146 Fredrick St.

15 Filed OCT 18 1915, 191 Max Jutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. (Month) 15th (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12th, 1915, to Oct 15th, 1915, that I last saw him alive on Oct. 15th, 1915, and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH * was as follows:

Acute Lobar pneumonia

(Duration) — yrs. — mos. 3 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Spurgeon Sparks M. D.

Oct. 15th, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ....yrs. ....mos. ....ds. In the State, ...yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sumner Cem

DATE OF BURIAL Oct 18, 1915

20 UNDERTAKER Louis Stein

ADDRESS City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 8

17016

(50)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Lonaconing (No. ....., ... St.; ..... Ward)

2 FULL NAME Mrs Margaret Byers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Dec (Month) 14th (Day) 1850 (Year)

7 AGE: 64 yrs. 9 mos. 24 ds. If LESS than 1 day, ... hrs. OR ..... min. ?

X OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Scotland

PARENTS

10 NAME OF FATHER: Isaac Wilson

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Agnes Telford

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ellis Byers

(Address) Lonaconing Md

15

Filed Oct 9, 1915 J O Bykert Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 8th (Day) 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 8th, 1915, to Oct 8th, 1915, that I last saw her alive on Oct 8th, 1915, and that death occurred on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ..... yrs. 10 mos. ..... ds.

Contributory Secondary: Diabetic gangrene

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) W D Skilling, M. D.

Oct 9th, 1915 (Address) Lonaconing

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Hill Cemetery — DATE OF BURIAL: Oct 10th, 1915

20 UNDERTAKER: M Eichhorn — ADDRESS: Lonaconing

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

17017

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany.

Village or City Cumberland (No. 13, Lee St. St.; Ward)

2 FULL NAME Mary Jane Cascaden.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Dec 10 (Month) (Day), 1851 (Year)

7 AGE: 63 yrs. 10 mos. 13 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): Home

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thos Tawcete

11 BIRTHPLACE OF FATHER (State or country): England

12 MAIDEN NAME OF MOTHER: Esther Dobbie

13 BIRTHPLACE OF MOTHER (State or country): Scotland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Cascaden

(Address) #3 Lee St.

15 Filed OCT 25 1915, 191 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 23rd (Month) (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10th, 1915, to Oct 23, 1915, that I last saw h on alive on Oct 22, 1915, and that death occurred on the date stated above, at 3.9, m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

Contributory Secondary Uremia?

(Duration) yrs. mos. 13 ds.

(Signed) C. B. McSmad, M. D.

Oct 23, 1915 (Address) Cumberland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Rose Hill Cem — DATE OF BURIAL: Oct 25, 1915

20 UNDERTAKER: Louis Stein — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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17018

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

1 PLACE OF DEATH

County Allegany.

Village or City Cumberland (No. 140 Offutt St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Roda Catlett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Oct 28, 1852 (Month) (Day) (Year)

7 AGE: 62 yrs. 11 mos. 15 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House work.
(b) General nature of industry business, or establishment in which employed (or employer): at Home

9 BIRTHPLACE (State or country): West Va.

PARENTS

10 NAME OF FATHER: Jefferson Largent

11 BIRTHPLACE OF FATHER (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Roda Peacemaker

13 BIRTHPLACE OF MOTHER (State or country): W. Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Catlett
(Address) Cumberland, Md.

15 Filed OCT 15 1915, 191 Max Guthrie REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 13, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept-15-, 1915, to Oct-13, 1915, that I last saw her alive on Oct 12, 1915, and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH * was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. 4 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Edward Harris, M. D.

Oct 15, 1915 (Address) Cumberland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Oct 15, 1915

20 UNDERTAKER: Tomlinson — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 6

17019

(40)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City village (No. Cresaptown St.; Ward)

2 FULL NAME Emily Cecil

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Feb (Month) 14 (Day), 1853 (Year)

7 AGE: 62 yrs. 7 mos. 29 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
X (a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry business, or establishment in which employed (or employer): at Home

9 BIRTHPLACE (State or country): West Va

PARENTS

10 NAME OF FATHER: Philip Vanmeter

11 BIRTHPLACE OF FATHER (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Susan Porter

13 BIRTHPLACE OF MOTHER (State or country): W. Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Cecil

(Address) Cresaptown, Md

15 Filed 10/16 191 6 M. D. Vanmeter, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 13 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1915, to Oct 12, 1915, that I last saw h[er] alive on Oct 12, 1915, and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH * was as follows:

Cancer of stomach

(Duration) 6 yrs. mos. ds.

Contributory / Secondary: Vomiting

(Duration) yrs. 1 mos. ds.

(Signed) J. Homer Wilson, M. D.

Oct 14, 1915 (Address) Cumberland Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cresaptown Md — DATE OF BURIAL: Oct 16, 1915

20 UNDERTAKER: Lewis Stein — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. .....

1 PLACE OF DEATH 17020

County Allegany

Village or City Cumberland (No. 139, Walnut St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Eugene Edward Cale

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH July (Month) 11 (Day), 1915 (Year)

7 AGE ..... yrs. 2 mos. 25 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer) none.

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Jos Cale

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Ella Lowery

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm J. Cale

(Address) 139 Walnut St.

15 Filed OCT 7 1915, 191 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. (Month) 6 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1915, to Oct 6, 1915, that I last saw h[illegible] alive on Oct 6, 1915, and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH * was as follows:

Gastroenteritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Right Inguinal Hernia

Contributory / Secondary

..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) R. W. Trevaskis, M. D.

Oct 6, 1915 (Address) Cumberland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL St Patrick Cemetery

DATE OF BURIAL Oct 8, 1915

20 UNDERTAKER Louis Stein

ADDRESS Cumberland

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

17021

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 11

155

[1] PLACE OF DEATH

County Allegany

Village or City Westernport (No. ____, ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

[2] FULL NAME J. Edward Cole

PERSONAL AND STATISTICAL PARTICULARS

[3] SEX: Male

[4] COLOR OR RACE: White

[5] SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

[6] DATE OF BIRTH: Sept 26 (Month), 1872 (Day, Year)

[7] AGE: 43 yrs. 0 mos. 13 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

[8] OCCUPATION
(a) Trade, profession, or particular kind of work: Paper hanger
(b) General nature of industry, business, or establishment in which employed (or employer):

330

[9] BIRTHPLACE (State or country): Md.

PARENTS

[10] NAME OF FATHER: Robert Cole

[11] BIRTHPLACE OF FATHER (State or country): Maryland

[12] MAIDEN NAME OF MOTHER: Martha Sherwood

[13] BIRTHPLACE OF MOTHER (State or country): Virginia

[14] THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J. Edw. Cole

(Address) Westernport Md

[15] Filed 10/12, 1915 W M Hallett Registrar

MEDICAL CERTIFICATE OF DEATH

[16] DATE OF DEATH: Oct (Month) 9 (Day), 1915 (Year)

[17] I HEREBY CERTIFY, That I attended deceased from Oct 4th, 1915, to Oct 9, 1915, that I last saw h~~im~~ alive on Oct 9, 1915, and that death occurred on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Ulcer Side of Tongue

Suicide

T.B. (Duration) five minutes yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) W M Hallett, M. D.

10/12, 1915 (Address) Westernport Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

[18] LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

[19] PLACE OF BURIAL OR REMOVAL: Philos cemetery — DATE OF BURIAL: Oct 12, 1915

[20] UNDERTAKER: W H Findlay, Westernport, Md. — ADDRESS: Piedmont

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. 49 Independent St.; 3 Ward)

2 FULL NAME Lillburn Cole

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wh

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct 20, 1915 (Month) (Day) (Year)

7 AGE: ___ yrs. ___ mos. ___ ds. If LESS than 1 day, ___ hrs. OR ___ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Harvey Cole

11 BIRTHPLACE OF FATHER (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Mayme Daue

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paulina Rossi

(Address) Cumberland Md

15 Filed Aug 9, 1916 Mac Fulton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 20, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ....., 191...,
and that death occurred on the date stated above, at ....m.

The CAUSE OF DEATH * was as follows:

Stillborn
From Inertia of uterus & rupture
pregnancy (Duration) ... yrs. mos. ... da.

Contributory / Secondary

(Duration) ... yrs. ... mos. ... da.

(Signed) Mac Fulton - Final Reg, M. D.

Aug 9 191 6 (Address) Cumberland Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... da. In the State, ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cremated

DATE OF BURIAL: Oct 20, 1915

20 UNDERTAKER: Parents

ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

17022

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. Alleg. Hosp St.; Ward)

2 FULL NAME Stidebowers Cooper

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH: Oct (Month) 25 (Day), 1915 (Year)

7 AGE: — yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: D. P. Cooper

11 BIRTHPLACE OF FATHER (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Mary Roden

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Roden

(Address) Cumberland Md.

15 Filed OCT 27 1915 Mar Sutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 25 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from — , 191 , to — , 191 , that I last saw h — alive on — , 191 , and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH * was as follows:

Still born

Immediate

(Duration) — yrs. — mos. — ds.

Contributory / Secondary Eclampsia of

mother (Duration) — yrs. — mos. — ds.

(Signed) J. R. Cowherd, M. D.

Oct 25, 1915 (Address) Ridgeley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State, — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Ridgeley W. Va.

Former or usual residence Ridgeley W. Va.

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Patrick Cem	Oct 28, 1915

20 UNDERTAKER	ADDRESS
Louis Steen	City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinomo, Sorcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17023

County Allegany

Village or City Cumberland (No. 462 Race St.; 6 Ward)

2 FULL NAME Hazel M. Couters

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Mar 29, 1894 (Month) (Day) (Year)

7 AGE: 20 yrs. 6 mos. 27 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer): Home

9 BIRTHPLACE (State or country): Pa

PARENTS

10 NAME OF FATHER: Charles H. Edmonds

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rebecca Kight

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Couters

(Address) 462 Race St.

15 Filed OCT 27 1915 M. Sutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ~~Aug~~ Oct 26, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1915, to Sept 25, 1915, that I last saw her alive on ~~Sept~~ 25, 1915, and that death occurred on the date stated above, at 2.10 a m.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 2 mos. ds.

Contributory Secondary: Exhaustion

(Duration) yrs. mos. 6 ds.

(Signed) C L Owens, M. D.

Oct 26, 1915 (Address) Cumberland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In this State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Rose Hill Cem. DATE OF BURIAL: Oct 28, 1915

20 UNDERTAKER: Louis Stein ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17024

(146)

County Allegany

Village or City Cumberland (No. 117, Md. Ave St.; Ward)

2 FULL NAME Earl W Cross

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH May 10, 1915
(Month) (Day) (Year)

7 AGE — yrs. 5 mos. 1 ds. If LESS than 1 day, ___ hrs. OR ___ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Robert J Cross

11 BIRTHPLACE OF FATHER (State or country) N. J.

12 MAIDEN NAME OF MOTHER Emma Davis

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert J Cross

(Address) 117 Md Ave

15 Filed OCT 12 1915, 191 [illegible]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 11, 1915.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1915 to Oct 11, 1915, that I last saw h[illegible] alive on Oct. 11, 1915, and that death occurred on the date stated above, at 2 p. m.

The CAUSE OF DEATH * was as follows:

Meningitis
Cerebro Spinal (Duration) yrs. 1 mos. 10 ds.

Contributory Secondary Mastoid Abscess (Duration) yrs. 2 mos. ds.

(Signed) J J Mann M. D.

Oct 14, 1915 (Address) 145 Bedford St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ...yrs. ...mos. ...ds. In the State, ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mount Zabler	Oct. 12, 1915

20 UNDERTAKER	ADDRESS
Louis Stein	Cumb'd

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

17025

104

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. Rear Wineow St.; Ward)

2 FULL NAME Hazel Irene Crowfis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Mar (Month) 17 (Day), 1915 (Year)

7 AGE: — yrs. 7 mos. 2 ds. If LESS than 1 day, ... hrs. OR ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): none

9 BIRTHPLACE (State or country): ~~Md~~ W. Va. Md.

PARENTS

10 NAME OF FATHER: Samual J Crowfis

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Snyder

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S J Crowfis

(Address) Cumberland Md

15 Filed OCT 21 1915, 191... Max Gruber
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 19 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1915, to Oct 19, 1915, that I last saw her alive on Oct 18, 1915, and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH * was as follows:

Entero Colitis

(Duration) ... yrs. 2 mos. ... ds.

Contributory Secondary: Convulsions

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. N. Lard, M. D.

Oct 20, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Rose Hill Cem — DATE OF BURIAL: Oct 21, 1915

20 UNDERTAKER: Louis Stein — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

115

1 PLACE OF DEATH 17026

County Allegany

Village or City Barnard (No. West Mallory St.; Ward)

2 FULL NAME Della Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Aug 6. (Month) (Day), 1882 (Year)

7 AGE: 33 yrs. 1 mos. 27 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Wife
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): W. Va

PARENTS

10 NAME OF FATHER: Amos Leatherman

11 BIRTHPLACE OF FATHER (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Laura Shearer

13 BIRTHPLACE OF MOTHER (State or country): W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEOGE

(Informant) William Davis

(Address) Blaine W. Va

15 Filed Oct. 3, 1915 Mat Horton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 3 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1915, to Oct. 2, 1915, that I last saw her alive on Oct 2, 1915, and that death occurred on the date stated above, at 1 a m.

The CAUSE OF DEATH * was as follows:

Oct. End acarditis in Coun of Acut Suppt. Cholecystitis, Cholangitis Bln + Stone in G.B. + Common duct also hepatic ducts (Duration) yrs. 10 mos. ds.

Contributory / Secondary: Cholecystectomy + Choledochotomy (Duration) yrs. mos. 2 ds.

(Signed) A N Hawkins, M. D.

Oct 3, 1915 (Address) Cumberland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 3 ds. In this State, yrs. mos. 3 ds.

Where was disease contracted, if not at place of death? Blaine W. Va

Former or usual residence: Blaine W Va

19 PLACE OF BURIAL OR REMOVAL: Blaine W. Va. DATE OF BURIAL: Oct 4, 1915

20 UNDERTAKER: Louis Stein ADDRESS: Cumberland

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 1

17027

(78)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

near Oldtown

Village ~~or City~~ Oldtown (No. ....., ... St.; ..... Ward)

2 FULL NAME Mary L Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Mulatto

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: July (Month) 11 (Day), 1857 (Year)

7 AGE: 58 yrs. 5 mes. 25 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer): Home

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: George Herpich

11 BIRTHPLACE OF FATHER (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Magaret Meyers

13 BIRTHPLACE OF MOTHER (State or country): Ger.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Davis

(Address) Oldtown Md.

15 Filed Oct 9, 1915 C. A. Skelley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 7th (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191.7., to Oct 7th, 191.5., that I last saw h.r alive on August, 191.5., and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH * was as follows:

Tuberculosis

..... (Duration) 5 yrs. ..... mos. ..... ds.

Contributory / Secondary: Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John R. Timmfield, M. D.

Oct 8th, 1915 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mt. Table Cem — DATE OF BURIAL: 10/10, 1915

20 UNDERTAKER: Louis Stein — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

1 PLACE OF DEATH 17028 (5)

County Allegany

Village or City Cumberland (No. 314, Oak St.; 6th Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Stillborn Dean

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fem	White	Single

6 DATE OF BIRTH: Oct (Month) 14 (Day), 1915 (Year)

7 AGE: Stillborn yrs. mos. ds. | If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Joseph P Dean

11 BIRTHPLACE OF FATHER (State or country) W Va

12 MAIDEN NAME OF MOTHER Mary C Seyman

13 BIRTHPLACE OF MOTHER (State or country) W Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Jos P. Dean

(Address) Cumberland Md

15 Filed OCT 15 1915 M K Lothian REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 14 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1915, to Oct 14, 1915, that I last saw h[illegible] alive dead on Oct 14, 1915, and that death occurred on the date stated above, at 7 p. m.

The CAUSE OF DEATH * was as follows:

Stillborn at about 4th month

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Geo L. Braudus M. D.

Oct 15, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cemetery	Oct 15, 1915

20 ~~UNDERTAKER~~ Funeral Director	ADDRESS
Joseph P Dean	Cumberland

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH 17029

County Allegany

Village or City Cumberland (No. 542 Green St.; Ward)

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Anna H. Doerner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH Jan (Month) 1 (Day), 1847 (Year)

7 AGE 68 yrs. 9 mos. 26 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housekaper
(b) General nature of industry business, or establishment in which employed (or employer) Home

9 BIRTHPLACE (State or country) Mass

PARENTS

10 NAME OF FATHER Cornealus Allen

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (State or country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ges Doerner

(Address) 542 Green St

15 Filed Dec 29, 1915 Thos Hinton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. (Month) 27 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1914, to Oct 27, 1915, that I last saw h— alive on Oct 25—, 1915, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH * was as follows:

Cancer

(Duration) 1 yrs. mos. ds.

Contributory Secondary Thrombosis

(Duration) yrs. mos. ds.

(Signed) Thos H. Ward, M. D.

Oct. 29, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St P.P. Cem — DATE OF BURIAL Oct 29 1915

20 UNDERTAKER Louis Staus — ADDRESS City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician; Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumania, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinama, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17030

County Allegany

Village or City Cumberland (No. 525 Green St.; 1 Ward)

2 FULL NAME Stella Edmundson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: — (Month) — (Day), 1881 (Year)

7 AGE: 34 yrs. — mos. — ds. | If LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): At Home.

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: D. K.

11 BIRTHPLACE OF FATHER (State or country): D K.

12 MAIDEN NAME OF MOTHER: Josephine Lewis

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Edmundson

(Address) 525 Green St.

15 Filed OCT 9 1915, 191 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 6 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1915, to Oct 6, 1915, that I last saw h[er] alive on Sept 15, 1915, and that death occurred on the date stated above, at 3 P m.

The CAUSE OF DEATH * was as follows:

Pulmonary Hemorrhage

(Duration) ... yrs. ... mos. 1 ds.

Contributory Secondary: Tuberculosis 2 yrs

(Duration) 2 yrs. ... mos. ... ds.

(Signed) J H Wilson, M. D.

Oct 7, 1915 (Address) Cumberland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Summerlee Cemetery | DATE OF BURIAL: Oct 9, 1915

20 UNDERTAKER: Jones Stein | ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

[1] PLACE OF DEATH 17031

County Allegany

Village or City Frostburg (No. ____, ____ St.; ____ Ward)

Registration Dist. No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

[2] FULL NAME Everline

PERSONAL AND STATISTICAL PARTICULARS

[3] SEX: Female

[4] COLOR OR RACE: White

[5] SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): Single

[6] DATE OF BIRTH: 10 (Month) 14 (Day), 1915 (Year)

[7] AGE: Still born — yrs. ____ mos. ____ ds.

If LESS than 1 day, ____ hrs. OR ____ min. ?

[8] OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): none

[9] BIRTHPLACE (State or country): Frostburg, Md.

PARENTS

[10] NAME OF FATHER: Phillip Everline

[11] BIRTHPLACE OF FATHER (State or country): Pa.

[12] MAIDEN NAME OF MOTHER: Anna E. Kroll

[13] BIRTHPLACE OF MOTHER (State or country): Frostburg Md

[14] THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna E. Everline

(Address) Frostburg Md.

[15] Filed Oct 20, 1915 D. L. Conroy
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

[16] DATE OF DEATH: 10 (Month) 19 (Day), 1915 (Year)

[17] I HEREBY CERTIFY, That I attended deceased from ____, 191__ to not at all, 191__

that I last saw h____ alive on ____, 191__

and that death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Still born.

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. C. Cooley, M. D.

10-19- 191__ (Address) Frostburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

[18] LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

[19] PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ____, 191__

[20] UNDERTAKER | ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. VI

17032

47

[If death occurred in a hospital or insfitution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Westernport (No. ____, ____ St.; ____ Ward)

2 FULL NAME Martin Foley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: December 5, 1856

58 years (Month) 10 (Day)

7 AGE: 58 yrs. 10 mos. 12 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishmeof in which employed (or employer)

9 BIRTHPLACE (State or country): West Virginia

PARENTS

10 NAME OF FATHER: Martin Foley

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Hardigan

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mazie Foley

(Address) Westernport, Md.

15 Filed Oct 19, 1915 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 17 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 12th, 1915 to Oct 17th, 1915, that I last saw h— alive on Oct 16th, 1915, and that death occurred on the date stated above, at 4 a- m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(Duration) 1 yrs. ____ mos. ____ ds.

Contributory Secondary: Heart failure

(Duration) ____ yrs. ____ mos. 2 1 ds.

(Signed) J. L. Wilson, M. D.

Oct 17th, 1915 (Address) Piedmont W Va

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Westernport Md — DATE OF BURIAL: 10/19, 1915

20 UNDERTAKER: W. N. Gresloch — ADDRESS: Piedmont Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

(113)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17033

County Allegany

Village or City Frostburg (No. 101, Park St.; Ward)

2 FULL NAME Rebecca Frisby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): Widow

6 DATE OF BIRTH: 9 (Month) 7 (Day) 1876 (Year)

7 AGE: 40 yrs. 1 mos. 4 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Samuel Bowers

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Sanders

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Williams

(Address) Westminster Md

15 Filed Oct 13, 1915 D. L. Conrey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 10 (Month) 11 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 30th, 1915 to Oct 11th, 1915, that I last saw h[illegible] alive on Oct 10th, 1915 and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

Autopsy

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Cardiac dilatation

Shock

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. C. Coley, M. D.

Oct. 11th, 1915 (Address) Frostburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Frostburg Md. DATE OF BURIAL: Oct. 13, 1915

20 UNDERTAKER: Jacob Kafer ADDRESS: Frostburg Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17034

County Allegany

Village ~~or City~~ Allegany (No. ....., ... St.; ..... Ward)

2 FULL NAME Consula Gallaway

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Black | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June (Month) 15 (Day), 1875 (Year)

7 AGE: 40 yrs. 4 mos. 8 ds. | If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Wm Fisher

11 BIRTHPLACE OF FATHER (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Susan Condra

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Gallaway

(Address) Frostburg Md

15 Filed Oct 26, 1915 D. L. Conway REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 10 (Month) 24 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 27th, 1915, to June 15-, 1915, that I last saw h.. alive on June 15th, 1915, and that death occurred on the date stated above, at 7 30 P.m.

The CAUSE OF DEATH * was as follows:

Died suddenly

Uremia - Senility

WB (Duration) ..... yrs. ..... mos. ..... ds.

Contributory
Secondary ..... (Duration) ..... yrs. ..... mes. ..... ds.

(Signed) J. Cooley M. D.

10-25-, 1915 (Address) Frostburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Romney W Va | DATE OF BURIAL: Oct 27, 1915

20 UNDERTAKER: Frostburg Furniture & Undertaking Co. | ADDRESS: Frostburg Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitiol nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 8

17035

(7)

1 PLACE OF DEATH

County Allegany

Village or City Lonaconing (No. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Earl Franklin Gelson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH: June (Month) 14 (Day), 1913 (Year)

7 AGE: 2 yrs. 3 mes. 25 ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Conjamsville Md

PARENTS

10 NAME OF FATHER: Frank Gelson

11 BIRTHPLACE OF FATHER (State or country): Allegany Co Md

12 MAIDEN NAME OF MOTHER: Isabella Brown

13 BIRTHPLACE OF MOTHER (State or country): Allegany Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Lloyd

(Address) Lonaconing

15 Filed Oct 10, 1915 — L. O. Bullock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 9 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1915, to Oct 9, 1915, that I last saw h— alive on Oct 9, 1915, and that death occurred on the date stated above, at 11:30 p m.

The CAUSE OF DEATH * was as follows:

Scarlatina Anginosa

(Duration) ..... yrs. ..... mos. 12 ds.

Contributory
Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James A. Bullock, M. D.

Oct 10, 1915 (Address) Lonaconing

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mes. ..... ds. In this State, ... yrs. ..... mes. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery Baltimore Pike near Cumberland — DATE OF BURIAL: Oct 12 1915

20 UNDERTAKER: A Pfeirolo — ADDRESS: Lonaconing Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

1 PLACE OF DEATH 17036

County Allegany

Village or City Cumberland (No. Western md. Hospital St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Harvey Groves

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widowed

6 DATE OF BIRTH Oct (Month) 15 (Day) 1865 (Year)

7 AGE 50 yrs. 5 mos. 6 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Charles Groves

11 BIRTHPLACE OF FATHER (State or country) Philadelphia

12 MAIDEN NAME OF MOTHER Mary Wigfield

13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ira L. Harmon

(Address) 215 Irondale St

15 Filed OCT 2 1915, 191 Mac Seiler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 1st (Month) (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28 -, 1915, to Oct 1 -, 1915, that I last saw him alive on Sept 30, 1915, and that death occurred on the date stated above, at 3a m.

The CAUSE OF DEATH * was as follows:

Delerium Tremens
Following an accident
Fell Off a Bridge

(Duration) yrs. mos. 1 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) D. W. A. Gracie, M. D.

Oct 1 1915 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 2½ ds. In the State, 15 yrs. mos. ds.

Where was disease contracted, if not at place of death? West Virginia

Former or usual residence ~~West Virginia~~ 96 Vine St-Cumb

19 PLACE OF BURIAL OR REMOVAL Rose Hill Cemetery — DATE OF BURIAL 10/5 1915

20 UNDERTAKER G. W. Seiler — ADDRESS City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

D. W. A. Gracie

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17037

County Allegany

Village or City Frostburg (No. 15 Bowery St.; Ward)

42

2 FULL NAME Carrie Hamel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: February 17, 1875 (Month) (Day) (Year)

7 AGE: 40 yrs. 7 mos. 27 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Solomon Hamel

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Jessie Cheney

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Morgan Hamel

(Address) Frostburg Md

15 Filed Oct 14, 1915 S. Dan'l. Conrad Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 13, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1915 to Oct 13th, 1915, that I last saw her alive on Oct 11th, 1915, and that death occurred on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix involving all surrounding tissues

(Duration) 1 yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) J Carey, M. D.

10-16-, 1915 (Address) Frostburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mes. ds. In the State yrs. mes. ds
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Frostburg Md — DATE OF BURIAL: Oct 15, 1915

20 UNDERTAKER: Jacob Kaper — ADDRESS: Frostburg Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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17038

30

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany.

Village or City Cumberland (No. 75 Weber St.; Ward)

2 FULL NAME James H Hanaroto

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH May 7 (Month), (Day), 1914 (Year)

7 AGE 1 yrs. 5 mos. 6 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Geo F Hanaroto

11 BIRTHPLACE OF FATHER (State or country) W. Va

12 MAIDEN NAME OF MOTHER Malinda Leasure

13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. F Hanaroto

(Address) 75 Weber St.

15 OCT 15 1915 Filed, 191 Mat Sutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October (Month) 13 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1915, to Oct. 13, 1915, that I last saw him alive on Oct 11, 1915, and that death occurred on the date stated above, at 4 p. m.

The CAUSE OF DEATH * was as follows:

Tubercular meningitis

(Duration) yrs. 1 mos. 13 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) R. W. Trevaskis, M. D.

Oct 13, 1915 (Address) Cumberland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Greenmount Cem. DATE OF BURIAL Oct 15, 1915

20 UNDERTAKER Louis Stein ADDRESS City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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17039

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. Allegany Hos St.; Ward)

2 FULL NAME John Harvey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Unknown (Month) (Day), 1888 (Year)

7 AGE: 27 yrs. — mos. — ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Machinist Helper
(b) General nature of industry business, or establishment in which employed (or employer): B & O.

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: John F. Harvey.

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary E. Shea.

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. S. Harvey.

(Address) 3 Polk St. Cumb.

15 Filed OCT 15 1915, 191 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 14. (Month) (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1915, to Oct. 14, 1915, that I last saw h[e] alive on Oct 14, 1915, and that death occurred on the date stated above, at 5a, m.

The CAUSE OF DEATH * was as follows:

Septic Pneumonia

4 Hours (Duration) yrs. mos. ds.

Contributory Secondary: Abscess Lung Chronic S.O.M.

Thrombosis (Duration) yrs. mos. 10 ds.

(Signed) G. P. Manert, M. D.

Oct. 14, 1915 (Address) 45 Bedford St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 4 ds. In the State 27 yrs. mos. ds.

Where was disease contracted, if not at place of death? Cumberland Md

Former or usual residence 51 Ann St

19 PLACE OF BURIAL OR REMOVAL: St. Pat Cem — DATE OF BURIAL: Oct 16, 1915

20 UNDERTAKER: Jamis Stein — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

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[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 10

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17040

County Allegany

Village or City Mt Savage (No. ....., ... St.; ..... Ward)

(45)

2 FULL NAME Henry Conrad Hauke[illegible]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH Aug 6th, 1846
(Month) (Day) (Year)

7 AGE 69 yrs. 1 mos. 29 ds. | If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Brewer
(b) General nature of industry, business, or establishment in which employed (or employer) -

314

9 BIRTHPLACE (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Hauke[illegible]

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Lang

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Sophia Hauke
(Address) Mt Savage

15 Filed Oct 5, 1915 — [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 5th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 11th, 1915 to Oct 5th, 1915, that I last saw h[illegible] alive on Oct 5th, 1915 and that death occurred on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Following Tracheo Bronchitis)
(Duration) 36 hrs. mos. ds.

Contributory Secondary Carcinoma of Larynx. Pharynx. Resp of Larynx Etc (Duration) yrs. 6 mos. ds.

(Signed) B. A. Lilliehy, M. D.
Oct 5th, 1915 (Address) Mt Savage

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Savage | DATE OF BURIAL Oct 8th, 1915

20 UNDERTAKER Jacob Hafer | ADDRESS Frostburg Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each aud every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employmeuts, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or iudustry, and therefore an additional liue is provided for the latter statemeut; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupatiou has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only defiuite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is iudefinite): *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congeuital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and cousequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medicai Association.)

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V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17041 (26)

County Allegany

Village or City Cumberland (No. 48, S. Mechanic St; Ward)

2 FULL NAME Ella Henry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June (Month) 19 (Day), 1876 (Year)

7 AGE: 40 yrs. 4 mos. 9 ds. | If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): New York State

PARENTS

10 NAME OF FATHER: William Pearson

11 BIRTHPLACE OF FATHER (State or country): England

12 MAIDEN NAME OF MOTHER: Catherine Clark

13 BIRTHPLACE OF MOTHER (State or country): England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clark E Henry

(Address) Cumberland Md

15 Filed OCT 30 1915, 191 Max Gerber, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 28 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1915, to Oct 27, 1915, that I last saw h[er] alive on Oct 27, 1915 and that death occurred on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 2 mos. ds.

Contributory (Secondary) Exhaustion

(Duration) yrs. mos. 10 ds.

(Signed) E L Clemens, M. D.

Oct 29, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. | In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Rose Hill Cem | DATE OF BURIAL: Oct 30, 1915

20 UNDERTAKER: Jamison Stein | ADDRESS: City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc.. *Carcinoma. Sarcoma.* etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis.* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse." "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

17042

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. 835, Lafayette Ave St.; Ward)

2 FULL NAME Sheehan Hazbell (Stillborn)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct (Month) 29 (Day), 1915 (Year)

7 AGE: ....yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. OR ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: J. W. Hazbell

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Bessie F Shoaty

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J W Hazbell

(Address) 835 Lafayette Ave Cumberland Md

15 Filed OCT 30 1915 191 Wm Fulton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 29 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from —, 191..., to —, 191...,
that I last saw her dead alive on ..., 191...,
and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH * was as follows:

Still Born Child

(Duration) ...yrs. ...mos. ...ds.

Contributory Secondary miscarriage 3rd month

(Duration) ...yrs. ...mos. ...ds.

(Signed) C E Owens M. D.

Oct 30 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ...yrs. ...mos. ...ds. In this State, ...yrs. ...mos. ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green mount — DATE OF BURIAL: Oct 30., 1915

20 UNDERTAKER: John C Wolford — ADDRESS: Cumberland

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*—(the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. VII

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17043

County Allegheny

Village or City McCoole (No. ....., ... St.; ..... Ward)

2 FULL NAME Thomas B. Jeffers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	Married

6 DATE OF BIRTH March (Month) 10th (Day) 1842 (Year)

7 AGE 73 yrs. 8 mos. 1 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) West Virginia

PARENTS

10 NAME OF FATHER A. Jeffers

11 BIRTHPLACE OF FATHER (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Susan Elliott

13 BIRTHPLACE OF MOTHER (State or country) New Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Orlando Pullman

(Address) Wheeling W. Va.

15 Filed 10/13, 1915 — [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October (Month) 11 (Day) 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from November, 1914 to Oct, 1915; that I last saw him alive on Sept. 6, 1915; and that death occurred on the date stated above, at 5 A m.

The CAUSE OF DEATH * was as follows:

Cerebral Apoplexy

(Duration) yrs. 11 mos. ..... ds.

Contributory .....
Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Babb, M. D.

Oct 13, 1915 (Address) Keyser W Va

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Keyser, W. Va. DATE OF BURIAL Oct. 13, 1915

20 UNDERTAKER J. H. Markwood Sons ADDRESS Keyser, W. Va.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

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V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

17044

(151)

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Allegany

Registration Dist. No. 41

Village or City Westernport (No. ________, ________ St.; ________ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Theresa Joseph

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: Female · 4 COLOR OR RACE: White · 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single	16 DATE OF DEATH: Oct 26, 1915 (Month) (Day) (Year)
6 DATE OF BIRTH: Oct. 6, 1915 (Month) (Day) (Year)	17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1915, to Oct 24, 1915, that I last saw her alive on Oct 24, 1915, and that death occurred on the date stated above, at 11.30 a.m.
7 AGE: ____ yrs. ____ mos. 20 ds. If LESS than 1 day ____ hrs. or ____ min.?	The CAUSE OF DEATH * was as follows: Premature birth 8 mo. Acute Inflation (Duration) ____ yrs. ____ mos. 20 ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work: Infant. (b) General nature of industry business, or establishment in which employed (or employer)	Contributory (Secondary) — (Duration) ____ yrs. ____ mos. ____ ds.
9 BIRTHPLACE (State or country): Westernport Md.	(Signed) J. McGallough, M. D.
PARENTS — 10 NAME OF FATHER: Abraham Joseph	10/26, 1915 (Address) Westernport Md.
11 BIRTHPLACE OF FATHER (State or country): Syria	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
12 MAIDEN NAME OF MOTHER: Martha Patrick	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
13 BIRTHPLACE OF MOTHER (State or country): Syria	Where was disease contracted, if not at place of death? Former or usual residence
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs A. Joseph (Address) Westernport Md	19 PLACE OF BURIAL OR REMOVAL: Westernport Md. · DATE OF BURIAL: Oct 26, 1915
15 Filed 10/28, 1915 J. McGallough REGISTRAR	20 UNDERTAKER: Mrs. J. F. Holmes · ADDRESS: Piedmont W Va

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

17045

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 14

1 PLACE OF DEATH

County Allegany

Outside of City Limits.

Village or City Cumberland (No. J.B. Sanitorium St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph M. Kalal

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	White	marri

6 DATE OF BIRTH July 11, 1877
(Month) (Day) (Year)

7 AGE 38 yrs. 9 ~~mos.~~ 18 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Clerk.
(b) General nature of industry business, or establishment in which employed (or employer) Harness maker

1877

9 BIRTHPLACE (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph M. Kalal

11 BIRTHPLACE OF FATHER (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Carrie McKenzie

13 BIRTHPLACE OF MOTHER (State or country) Cumberland. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie R. Kalal

(Address) Cumberland Md

15 Filed NOV 1 - 1915, 1915 Max Gutten
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 - 29, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 20th 1915, to Oct 29th, 1915, that I last saw h im alive on Oct 29th, 1915, and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

(Duration) unknown to me yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) F H Wolfe, M. D.

10/31, 1915 (Address) Cumberland, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 10 ds. In the State 37 yrs. 3 mos. 10 ds.

Where was disease contracted, if not at place of death? Balto md.

Former or usual residence Balto md

19 PLACE OF BURIAL OR REMOVAL St Patrick Cem

DATE OF BURIAL Oct 2, 1915

20 UNDERTAKER Geo Shinn

ADDRESS Cumb

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. VI

17046

78

1 PLACE OF DEATH
County Allegany
Village or City Piedmont (No. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Genevieve Kirk

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH: ~~December~~ (Month) 11 (Day), 1886 (Year)

7 AGE: 28 yrs. 9 mos. 20 ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Stayed at Home
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Piedmont

PARENTS

10 NAME OF FATHER: John Kirk
11 BIRTHPLACE OF FATHER (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Mary Wadger
13 BIRTHPLACE OF MOTHER (State or country): Pinidence

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Kirk
(Address) Westernport Md

15 Filed Dec 3, 1915 ~~Wallace~~ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 1st (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1914, to Oct, 1915; that I last saw him alive on Sept 30, 1915; and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH * was as follows:
Pulmonary Tuberculosis

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory
Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D J Long, M. D.
Oct 1, 1915 (Address) Piedmont W Va

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Westernport Md	Oct 4, 1915

20 UNDERTAKER	ADDRESS
Mrs J F Horlacher	Piedmont

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

17047

104

County Allegany

Village or City Cumberland (No. 80, Decatur St.; Ward)

2 FULL NAME Gretta Louise Kennell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Dec. (Month) 10, (Day) 1914 (Year)

7 AGE: yrs. 10 mos. 18 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Pa

PARENTS

10 NAME OF FATHER: A. C. Kennell

11 BIRTHPLACE OF FATHER (State or country): Pa

12 MAIDEN NAME OF MOTHER: Elza Staub.

13 BIRTHPLACE OF MOTHER (State or country): Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A C Kennell

(Address) 80 Decatur St.

15 Filed Oct 29, 1915 M. McLorton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 28 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1915, to Oct 28, 1915, that I last saw h— alive on Oct 27, 1915, and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH * was as follows:

Acute Entero Colitis

(Duration) yrs. mos. 11 ds.

Contributory Secondary: Exhaustion

(Duration) yrs. mos. ds.

(Signed) F. Alan F. Murray, M. D.

Oct 28, 1915 (Address) Md Lancaster

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Meyersdale Pa. DATE OF BURIAL: Oct. 29, 1915

20 UNDERTAKER: Louis Stein ADDRESS: City.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 12

17048

89

1 PLACE OF DEATH

County Allegany

Village or City Midland (No. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Simon Kenny

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	married

6 DATE OF BIRTH: unknown (Month) (Day), 1836 (Year)

7 AGE: about 79 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thomas Kenny

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary O'Byrne

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Thomas Kenny

(Address) Cumberland Md.

15 Filed Oct 30, 1915 F H Charles
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 29th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from October 21st, 1915, to October 29th 1915, that I last saw him alive on October 29th, 1915, and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH * was as follows:

Acute Bronchitis

(Duration) ..... yrs. ..... mos. 8 de.

Contributory Secondary ..... (Duration) ..... yrs. ..... mos. ..... de.

(Signed) M. J. McDermott, M. D.

Oct 29th, 1915 (Address) Midland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... de. In this State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Michaels Frostb — DATE OF BURIAL: Nov 2, 1915

20 UNDERTAKER: J. J. Durst — ADDRESS: Frostburg

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany 17049 (S) Outside of City Limits.

Village or City Cumberland (No. Narrows Park St.; Ward)

2 FULL NAME Hilbert Kellander

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct 17, 1915 (Month) (Day) (Year)

7 AGE: 0 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. OR min. ? 6 months 6 days

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Allegany Md

PARENTS

10 NAME OF FATHER: Edw. Kellander

11 BIRTHPLACE OF FATHER (State or country): Stenta Sweden

12 MAIDEN NAME OF MOTHER: Mary C Shondel

13 BIRTHPLACE OF MOTHER (State or country): Patterson Creek W Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw Kellander

(Address) Narrows Park Cumbd Md

15 Filed OCT 19 1915 191 M A Lydon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 17 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10/17, 1915, to 10/17, 1915, that I last saw h alive on , 191 , and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Over work on moths
Poor, Cerebro gastritis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) E T Kaphel, M. D.

10/19, 1915 (Address) 82 Bedford St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: No membrane — DATE OF BURIAL: , 191

20 UNDERTAKER — ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 12

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany 17050

(120)

Village or City Lord (No. ..... St.; ..... Ward)

2 FULL NAME Susanna Kovacsal

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH: not Known (Month) ....., 1 (Day) ....., (Year)

7 AGE: Exact age not Known — about 70 yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry business, or establishment in which employed (or employer): House work

9 BIRTHPLACE (State or country): Osta Hungary

PARENTS

10 NAME OF FATHER: not Known

11 BIRTHPLACE OF FATHER (State or country): Hungary

12 MAIDEN NAME OF MOTHER: not Known

13 BIRTHPLACE OF MOTHER (State or country): Hungary

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Mathiews

(Address) Lord Md

15 Filed Oct 7, 1915 F. H Eades REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 6th (Month) (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1915, to October 6th, 1915, that I last saw her alive on October 5th, 1915, and that death occurred on the date stated above, at 1st A. m.

The CAUSE OF DEATH * was as follows:

Chronic Interstitial Nephritis

(Duration) ..... yrs. 3 mos. 26 ds.

Contributory Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. J. McDermott, M. D.

Oct. 6th, 1915 (Address) Midland-Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Allegany Cemet	10/8/, 1915
20 UNDERTAKER	ADDRESS
J. L Luset	Frostburg

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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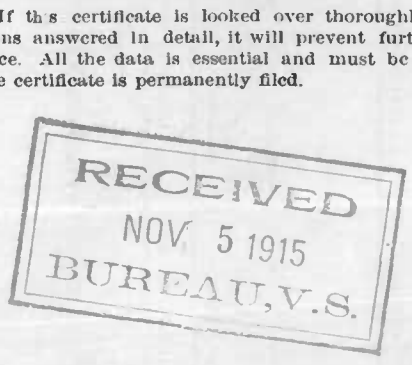

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

17051

67

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Frostburg (No. ....., ... St.; ..... Ward)

2 FULL NAME Andrew Lapp

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): married

6 DATE OF BIRTH: January (Month) 21 (Day) 1844 (Year)

7 AGE: 71 yrs. 10 mos. — ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer): mining

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Lapp

11 BIRTHPLACE OF FATHER (State or country):

12 MAIDEN NAME OF MOTHER: Cunigunda Bode

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Lapp

(Address) Cumberland Md

15 Filed Oct 31 1915 D. F. L. Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 30 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1914 to Oct 30 1915, that I last saw h[illegible] alive on Oct 1 1915 and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Paresis for over a year. Died suddenly - presumably from Apoplexy.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory
Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Green, M. D.

10-31 1915 (Address) Frostburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Allegany Co. DATE OF BURIAL: Nov 2, 1915

20 UNDERTAKER: Jacob Hafer ADDRESS: Frostburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

STATE OF MARYLAND
CERTIFICATE OF DEATH

17052

175

1 PLACE OF DEATH

County Allegany

~~Village or~~ City Cumberland (No. ....., B & O. Ry Co. Yards, St.; ..... Ward)

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Preston Leasure

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ (Write the word): Widower

6 DATE OF BIRTH: Nov. (Month) 19 (Day), 1883 (Year)

7 AGE: 31 yrs. 10 mos. 28 ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Air Insp. Tester
(b) General nature of industry business, or establishment in which employed (or employer): B & O Ry Co

9 BIRTHPLACE (State or country): Allegany Co.

PARENTS

10 NAME OF FATHER: Isaac Leasure

11 BIRTHPLACE OF FATHER (State or country): Bedford Co., Pa

12 MAIDEN NAME OF MOTHER: Martha Ann Pence

13 BIRTHPLACE OF MOTHER (State or country): Unknown.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Milton Dicken

(Address) 120 So. Centre St.

15 Filed OCT 19 1915, 191 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 17 (Month) (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I last saw h... alive on ....., 191...,
and that death occurred on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Crushed By Car
B & O R. R. Accident

(Duration) ... yrs. ... mos. ... ds.

Contributory
Secondary

(Duration) ... yrs. ... mos. ... ds.

(Signed) Wm. H. Shaw Coroner M. D.

Oct 19, 1915 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: German Lutheran Cemty

DATE OF BURIAL: 10-18, 191 5

20 UNDERTAKER: G. S. Butler

ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto. Requesting V. S. No. 1.

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 12

(151)

1 PLACE OF DEATH 17053

County Allegany

Village or City Ocean (No. # 2 St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John E Logsdon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	Child

6 DATE OF BIRTH Dec 31 (Month) (Day) 1914 (Year)

7 AGE yrs. 9 mos. 14 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work child
(b) General nature of industry business, or establishment in which employed (or employer) "

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Walter Logsdon

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Lizzie E. Schurg

13 BIRTHPLACE OF MOTHER (State or country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Schurg

(Address) Ocean

15 Filed Oct 14, 1915 F H Thuer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 13th (Month) (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from October 8th, 1915, to October 13th, 1915; that I last saw him alive on October 13th, 1915, and that death occurred on the date stated above, at 4.30 P m.

The CAUSE OF DEATH * was as follows:

Marasmus

(Duration) yrs. 2/12 mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) M. J. McDermott, M. D.

Oct. 14th, 1915 (Address) Midland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Methodist Cemet DATE OF BURIAL 10/15, 1915

20 UNDERTAKER Mt Sav ADDRESS Frostburg

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY—and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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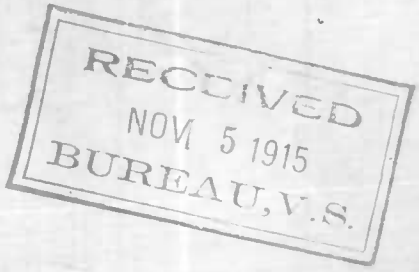

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V. S. No. 1.

17054

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 12

(S)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Midland (No. ....., ... St.; ..... Ward)

2 FULL NAME Daly McGreevy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
male	white	single

6 DATE OF BIRTH October 12th, 1915
(Month) (Day) (Year)

7 AGE ..... yrs. 11 mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER John McGreevy

11 BIRTHPLACE OF FATHER (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Byrnes

13 BIRTHPLACE OF MOTHER (State or country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John McGreevy

(Address) Midland-Md.

15 Filed Nov 4, 1915 F A Charles
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 12th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12th, 1915, to Oct. 12th, 1915, that I last saw her alive on Oct. 12th, 1915, and that death occurred on the date stated above, at 10 a. A. m.

The CAUSE OF DEATH* was as follows:

Miscarriage

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. J. McDermott, M. D.

Nov. 4th, 1915 (Address) Midland-Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ....., 191....

20 UNDERTAKER | **ADDRESS**

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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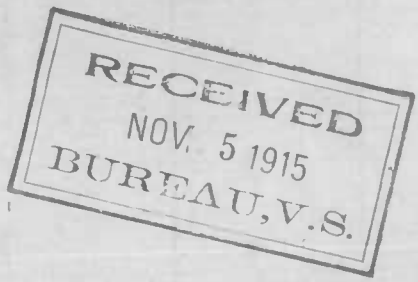

V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH 17055 (175)

County Allegany

Registration Dist. No. 8

Village or City Cumberland (No. W Md Hospital St.; .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James O Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct (Month) 10 (Day), 1897 (Year)

7 AGE 18 yrs. — mos. 7 ds. If LESS than 1 day, ...hrs. OR ...min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Apprentice Machinist
(b) General nature of industry business, or establishment in which employed (or employer) B & O Ry Co.

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Michiel H Miller

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Nettie Langly

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Michiel H Miller

(Address) 69 Ascension St.

15 Filed OCT 20 1915 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 17 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1915, to Oct 17, 1915, that I last saw him alive on Oct 17, 1915, and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Crushed thigh - Scalped cut face & body

accident: hit by Boot's Hey a Moving from Shoot

(Duration) ...... yrs. ...... mos. ...... ds.

Contributory Secondary

(Duration) ...... yrs. ...... mos. 5 hrs ds.

(Signed) E B Claybrook, M. D.

Oct 19, 1915 (Address) 61 Washington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ...... yrs. ...... mos. 4 hrs. In the State, 18 yrs. — mos. 7 ds.

Where was disease contracted, if not at place of death? Okonoko W Va.

Former or usual residence Cumberland Md.

19 PLACE OF BURIAL OR REMOVAL Rose Hill Cem

DATE OF BURIAL Oct 20, 1915

20 UNDERTAKER Louis Stein

ADDRESS City.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetonus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

17056

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. 187 N. Mechanic St.; Ward)

2 FULL NAME Walter Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Oct 24, 1868 (Month) (Day) (Year)

7 AGE: 47 yrs. 0 mos. 1 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Stone Mason
(b) General nature of industry business, or establishment in which employed (or employer): Contractor

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Irvin Miller

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (State or country): "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Urban Miller

(Address) Valley St City

15 Filed OCT 27 1915 Wm Hutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 25, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1915, to Oct 25, 1915, that I last saw him alive on Oct. 24, 1915, and that death occurred on the date stated above, at 11 A m.

The CAUSE OF DEATH * was as follows:

Tuberculosis of Lungs

(Duration) 8 yrs. mos. ds.

Contributory Secondary: Exhaustion

(Duration) yrs. mos. ds.

(Signed) Thos. H. Thomas, M. D.

Oct 26, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St. P. & P. Cem. DATE OF BURIAL: Oct 28 1915

20 UNDERTAKER: Louis Stein ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17057

County Allegany

Village or City Frostburg (No. Miners Hospital St.; Ward)

2 FULL NAME Dead boon female (Payne)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word)

6 DATE OF BIRTH: 10 (Month) 24 (Day), 1915 (Year)

7 AGE: ____ yrs. ____ mos. ____ ds.

If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo H. Payne

11 BIRTHPLACE OF FATHER (State or country) W. Va

12 MAIDEN NAME OF MOTHER Cora L. Weimer

13 BIRTHPLACE OF MOTHER (State or country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D W McLane
(Address) Frostburg Md

15 Filed Oct 25, 1915 D. L. Conroy
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 10 (Month) 24 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1915, to Oct 24, 1915, that I ~~last saw him alive on~~ ____, 191__, ~~And that~~ death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:
Dead born - (mother had Eclampsia)

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) D W McLane, M. D.
Oct 27, 1915 (Address) Frostburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Allegany Cem. DATE OF BURIAL: Oct 25, 1915

20 UNDERTAKER: Frostburg Furniture & Undertaking Co. ADDRESS: Frostburg Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. One

17058

105

[1] PLACE OF DEATH

County Allegany

Village or City Little Orleans (No. ____ Md. ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

[2] FULL NAME Mary Madeline Falls

PERSONAL AND STATISTICAL PARTICULARS

[3] SEX: Female

[4] COLOR OR RACE: White

[5] SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

[6] DATE OF BIRTH: Not Known ____ (Month) ____ 1 (Day) ____ (Year)

[7] AGE: about 61 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. OR ____ min.?

[8] OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ____

[9] BIRTHPLACE (State or country): Maryland.

PARENTS

[10] NAME OF FATHER: Not Known

[11] BIRTHPLACE OF FATHER (State or country): Not-Known

[12] MAIDEN NAME OF MOTHER: Not-Known

[13] BIRTHPLACE OF MOTHER (State or country): Not-Known

[14] THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Hetherhouse

(Address) Little Orleans Md

[15]

Filed Oct 9, 1915. T. T. Mann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

[16] DATE OF DEATH: October (Month) 8 (Day), 1915 (Year)

[17] I HEREBY CERTIFY, That I attended deceased from October 6th, 1915, to October 6th, 1915, that I last saw her alive on October 6th, 1915, and that death occurred on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion and Heart Failure,

(Duration) ____ yrs. ____ mos. 6 ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) John A Watson, M. D.

October 9, 1915. (Address) Piney Grove Md

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

[18] LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds

Where was disease contracted, if not at place of death?

Former or usual residence

[19] PLACE OF BURIAL OR REMOVAL: Little Orleans — DATE OF BURIAL: Oct 10, 1915

[20] UNDERTAKER: E Ahram Smith — ADDRESS: Ingle Pa.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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STATE OF MARYLAND
CERTIFICATE OF DEATH

17059

(9)

Registration Dist. No. 9

1 PLACE OF DEATH
County Allegany
Village or City Frostburg (No. Bowery St.; Ward)
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edda Price

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: May 27, 1909 (Month) (Day) (Year)

7 AGE: 6 yrs. 6 mos. 19 ds. If LESS than 1 day, hrs. OR mo.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md

PARENTS
10 NAME OF FATHER: John Price
11 BIRTHPLACE OF FATHER (State or country): Md
12 MAIDEN NAME OF MOTHER: Grace Stewart
13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Price
(Address) Frostburg Md

15 Filed Oct 16, 1915 C. L. Conrey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 16 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1915, to Oct 16, 1915, that I last saw h[illegible] alive on Oct 16, 1915, and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH * was as follows:
Diphtheria - Croup
Child sick 5 days before a Physician was called

(Duration) — yrs. — mos. 6 ds.

Contributory Secondary: Diphtheritic Croup-Heart failure

(Duration) yrs. mos. 1 ds.

(Signed) C. L. Conrey, M. D.
Oct 16, 1915 (Address) Frostburg Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Allegany Cem
DATE OF BURIAL: Oct 17, 1915

20 UNDERTAKER: Frostburg Fun. Und Co
ADDRESS: Frostburg

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

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V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be careful'y supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

(104)

1 PLACE OF DEATH 17060

County Allegany

Village or City Cumberland (No. 132, Hinkley St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jennie F Reed

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	white	Single

6 DATE OF BIRTH: May 23, 1913 (Month) (Day) (Year)

7 AGE: 2 yrs. 4 mos. 26 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
X (a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): W. Va.

PARENTS

10 NAME OF FATHER: Grover Reed

11 BIRTHPLACE OF FATHER (State or country): W Va

12 MAIDEN NAME OF MOTHER: Mary Dyer

13 BIRTHPLACE OF MOTHER (State or country): W Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grover Reed

(Address) Cumberland

15 Filed OCT 20 1915, 191 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 19 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1915, to Oct 19, 1915, that I last saw her alive on Oct 19, 1915, and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH * was as follows:

acute Tuberculosis

(Duration) yrs. 1 mos. ds.

Contributory Secondary: malnutrition

(Duration) yrs. 4 mos. 26 ds.

(Signed) C L Owens, M. D.

Oct 20, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dyer Cemetery Md	Oct 21, 1915

20 UNDERTAKER	ADDRESS
John A Walford	Cumberland

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH 17061 (56)

County Allegany. Registration Dist. No. 7

Village or City Frostburg (No. 129 Bowery St.; Ward) Miners Hospital.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME David Reese

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	white	Single

6 DATE OF BIRTH: Sept. (Month) 29 (Day) 1870 ~~1869~~ (Year)

7 AGE: 46 yrs. 0 mos. 25 ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Coal miner.
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: John D. Reese

11 BIRTHPLACE OF FATHER (State or country): South Wales

12 MAIDEN NAME OF MOTHER: Morgaret Jones

13 BIRTHPLACE OF MOTHER (State or country): South Wales

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Reese
(Address) Bowery St Frostburg

15 Filed Oct 25th, 1915 P. L. Conroy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 24th (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from October 24th, 1915, to October 24th, 1915, that I last saw him alive on October 24th, 1915, and that death occurred on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
oedema of Brain.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory Chronic Alcoholism

Secondary and Exposure (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Michel, M. D.

Oct. 24th 1915 (Address) Frostburg Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Allegany Co. DATE OF BURIAL: 10/27, 1915

20 UNDERTAKER: Frostburg Fun Home ADDRESS: Frostburg Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17062

County Allegany

Village or City Cumberland (No. 2, Highland Place, Ward)

2 FULL NAME Seelbain Rodenhauser

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Unknown

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct 17, 1915 (Month) (Day) (Year)

7 AGE: ____ yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: George Rodenhauser

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Blanche Seigler

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. J. K. Dixon

(Address) Cumberland Md

15 Filed Oct 20, 191 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 17 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 191 5 to Oct 17, 191 5, that I last saw ~~him~~ her alive on Oct 17, 191 5, and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH * was as follows:

Stillborn

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. H. Wilson, M. D.

Oct 19, 191 5 (Address) Cumberland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In this State, ____ yrs. ____ mos. ____ ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cremation — DATE OF BURIAL: Oct 20, 191 5

20 ~~UNDERTAKER~~ Father — ADDRESS: George Rodenhauser City.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

17063

79

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. 220, Grand Ave St.; Ward)

2 FULL NAME Mary Ellen Roberts

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: June 11 (Month) (Day), 1839 (Year)

7 AGE: 76 yrs. 3 mos. 24 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Va

PARENTS

10 NAME OF FATHER: Samuel Betzer

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Anna Rye

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Holbday

(Address) 220 Grand Ave

15 Filed OCT 6 1915, 191 Wm Hutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 5 (Month) (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 1- 1913, to Oct 6 1915, that I last saw her alive on Oct 5 1915, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH * was as follows:

Valvular heart disease with arteriosclerosis

(Duration) 3 yrs. mos. ds.

Contributory Secondary Uraemia + Exhaustion

(Duration) yrs 2 mos. ds.

(Signed) F. P. Barndell M. D.

Oct 6, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Martinsburg W Va

DATE OF BURIAL: Oct. 7, 1915

20 UNDERTAKER: Louis Stein

ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

17064

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

1 PLACE OF DEATH

County Allegany.

Village or City Cumberland (No. Allegany Ave. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Margaret H Schadt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Divorced

6 DATE OF BIRTH: June 22, 1886 (Month) (Day) (Year)

7 AGE: 29 yrs. 3 mos. 18 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry business, or establishment in which employed (or employer): At Home

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Conrad Schadt

11 BIRTHPLACE OF FATHER (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mard Stotting

13 BIRTHPLACE OF MOTHER (State or country): Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Henry Schadt
(Address) Wapleside

15 Filed: OCT 11 1915 Max Tolton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 10, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1915, to Oct 10, 1915; that I last saw her alive on Oct 9, 1915; and that death occurred on the date stated above, at 2 P m.

The CAUSE OF DEATH * was as follows:

Sarcoma of Liver

(Duration) — yrs. 6 mos. — ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) A. L. Faulkner, M. D.

Oct 11, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. 1 mos. 5 ds. In the State, yrs. 7 mos. ds.
Where was disease contracted, if not at place of death? Davis W. Va.
Former or usual residence Davis W. Va.

19 PLACE OF BURIAL OR REMOVAL: Ger Reformed Cem — DATE OF BURIAL: Oct 13, 1915

20 UNDERTAKER: Louis Steve — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

17065

(3)

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. West Md Hos St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant Scheermesser

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH: Oct (Month) 10 (Day), 1915 (Year)

7 AGE: — yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Walter Scheermesser

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Jessie Lee Magaha

13 BIRTHPLACE OF MOTHER (State or country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Scheermesser

(Address) Cumberland Md

15 Filed OCT 11 1915 Mac Foulton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 10 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 10 1915, to Oct 10 1915, that I last saw him dead alive on —, 191—; and that death occurred on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

(1) Placent Praevia during
(2) partum.

(Duration) — yrs. — mos. — ds.

Contributory Secondary —

(Duration) — yrs. — mos. — ds.

(Signed) John R Linnfield, M. D.

Oct 11, 1915 (Address) Cumberland, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death —yrs. —mos. —ds. In this State, —yrs. —mos. —ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Germain Cemetery (b'k) DATE OF BURIAL: Oct 11, 1915

20 UNDERTAKER: Louis Stein ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

1 PLACE OF DEATH 18112 (74)

County Allegany

Village or City Cumb'd (No. W. Md Hospital St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

2 FULL NAME Solomon W. Schiller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH — — , 1879
(Month) (Day) (Year)

7 AGE 26 yrs. — mos. — ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry business, or establishment in which employed (or employer) Farm

9 BIRTHPLACE (State or country) Pa.

PARENTS

10 NAME OF FATHER John B. Schiller

11 BIRTHPLACE OF FATHER (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margerette Weimold

13 BIRTHPLACE OF MOTHER (State or country) Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norman B. Schiller

(Address) 48 Holland St City

15 Filed OCT 11 1915, 191 — Mat Gerstad REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 9, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1915, to Oct. 9, 1915, that I last saw h[im] alive on Oct. 9th, 1915, and that death occurred on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH * was as follows:

Fracture of skull (accidental)

(Duration) 17 yrs. mos. ds.

Contributory Cerebral cyst
Secondary

(Duration) 3 yrs. mos. ds.

(Signed) W. R. Hodges, M. D.

Oct. 9, 1915 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 1½ ds. In the State, yrs. mos. 1½ ds.

Where was disease contracted, if not at place of death? Glencoe, Pa.

Former or usual residence Glencoe, Pa.

19 PLACE OF BURIAL OR REMOVAL Glencoe Pa — DATE OF BURIAL Oct 12, 1915

20 UNDERTAKER Louis Stein — ADDRESS City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17066

County Allegany

Village or City Cumberland (No. 410, Green St.; Ward)

2 FULL NAME Barbara Schilling

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH June 26, 1847 (Month) (Day) (Year)

7 AGE 68 yrs. 3 mos. 25 ds.

If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer) Home

9 BIRTHPLACE (State or country) Germany

PARENTS

10 NAME OF FATHER John C Dellhop

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Margret Niegel

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sylvester Schilling

(Address) City

15 Filed OCT 23 1915 Max Keelton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 21, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec., 1914, to Oct 21st, 1915, that I last saw h[illegible] alive on Oct. 20th, 1915, and that death occurred on the date stated above, at 6P m.

The CAUSE OF DEATH * was as follows:

Cardiac Hemorrhage

(Duration) yrs. 8 mos. ds.

Contributory Secondary Nephritis

(Duration) yrs. mos. ds.

(Signed) John R Lunsford, M. D.

Oct 23, 1915 (Address) Cumberland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rose Hill Cem — DATE OF BURIAL Oct 23, 1915

20 UNDERTAKER Louis Steve — ADDRESS City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

17067

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Frostburg (No. ..., Water St.; ... Ward)

2 FULL NAME Robert Scott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): widower

6 DATE OF BIRTH: Aug (Month) 25 (Day), 1836 (Year)

7 AGE: 79 yrs. 2 mos. ... ds. If LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): none

9 BIRTHPLACE (State or country): Scotland

PARENTS

10 NAME OF FATHER: John Scott

11 BIRTHPLACE OF FATHER (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Jannie Frew

13 BIRTHPLACE OF MOTHER (State or country): Scotland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. R. Scott

(Address) Wheeling W. Va.

15 Filed Oct 26, 1915 D. L. Curry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 24 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 —, 1915, to Oct 24, 1915, that I last saw h... alive on Oct 24, 1915, and that death occurred on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

Contributory Secondary ~~Fever~~ Senility

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. M. Green, M. D.

Oct 25, 1915 (Address) Frostburg, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Allegany Cem — DATE OF BURIAL: 10/27, 1915

20 UNDERTAKER: ...burg Furniture & Undertaking Co. — ADDRESS: Frostburg Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired* 6 *yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congeultal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

17068 (15)

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Allegany

Village or City Frostburg (No. Eckhart Flats St.; Ward)

Registration Dist. No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Shehee

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX M. / 4 COLOR OR RACE W. / 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) —	16 DATE OF DEATH 10 (Month) 7 (Day), 1915 (Year)
6 DATE OF BIRTH 10 (Month) 7 (Day), 1915 (Year)	17 I HEREBY CERTIFY, That I attended deceased from Not at all, 191 , to , 191 , that I last saw h alive on , 191 , and that death occurred on the date stated above, at m.
7 AGE yrs. mos. ds. If LESS than 1 day, 1 hrs. OR min.?	The CAUSE OF DEATH * was as follows: Miscarriage (Duration) yrs. mos. ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work — (b) General nature of industry business, or establishment in which employed (or employer)	Contributory Secondary (Duration) yrs. mos. ds.
9 BIRTHPLACE (State or country) Md	(Signed) J. C. Perry M. D. 10-7-1915 (Address) Frostburg Md
PARENTS 10 NAME OF FATHER John L. Shehee	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
11 BIRTHPLACE OF FATHER (State or country) Md	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
12 MAIDEN NAME OF MOTHER Jane B. Leahe	At place of death yrs. mos. ds. In the State, yrs. mos. ds.
13 BIRTHPLACE OF MOTHER (State or country) Md	Where was disease contracted, if not at place of death? Former or usual residence
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Jno L. Shehee (Address) Cumberland Md	19 PLACE OF BURIAL OR REMOVAL / DATE OF BURIAL , 191
15 Filed Oct 8, 1915 D. T. L. Conway REGISTRAR	20 UNDERTAKER / ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

17089

151

1 PLACE OF DEATH

County Allegany

Village or City Frostburg (No. Eckhart Fld St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sheher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)
M.	C	

6 DATE OF BIRTH 10 (Month) 7 (Day), 1915 (Year)

7 AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, 2 hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Jno. F. Sheher

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Jane B. Sheher

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno. F. Sheher

(Address) Cumberland

15 Filed Oct 8, 1915 Wm. L. Conway REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 (Month) 7 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 191.., to ....., 191...., that I last saw h..... alive on ....., 191..., and that death occurred on the date stated above, at .....m.

The CAUSE OF DEATH * was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory
Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Carlson, M. D.

10-7-, 191.. (Address) Frostburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191....

20 UNDERTAKER | ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 11

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH 17070

County Allegany

Village or City Eckhart (No. ..... St.; ..... Ward)

2 FULL NAME John S Kelley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Unknown (Month) ..... (Day) 1 (Year)

7 AGE about 81 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Penna -

PARENTS

10 NAME OF FATHER Jos Kelley

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Kelley

(Address) Eckhart Md

15

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 (Month) - 1 (Day), 1913 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1913, to Sept 7, 1913, that I last saw him alive on Sept 6, 1913, and that death occurred on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory Secondary Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) 10/2 Geo H Wilson, M. D.

....., 1913 (Address) Eckhart Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death?

Former or usual residence Unknown Md

19 PLACE OF BURIAL OR REMOVAL Eckhart

DATE OF BURIAL 10/4, 1913

20 UNDERTAKER J Harper

ADDRESS Frostburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia." "Anaemia" (merely symptomatic), "Atrophy." "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany 17071 (104)

Village or City Cumberland (No. 157, Fayette St.; Ward)

2 FULL NAME Floyd Washington Spies

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Sept 9, 1915 (Month) (Day) (Year)

7 AGE: — yrs. 1 mos. 15 ds.

If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Henry Spies

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Daisy Hornbaker (Hornickel)

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Spies

(Address) Cumberland Md

15 Filed OCT 25 1915 M A Sutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 24, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1915, to Oct 24, 1915, that I last saw h[im] alive on Oct 21, 1915, and that death occurred on the date stated above, at 5-8 m.

The CAUSE OF DEATH * was as follows:

Marasmus

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary Gastro-enteritis

(Duration) ..... yrs. ..... mos. about 20 ds.

(Signed) H. L. Downing, M. D.

Oct 25, 1915 (Address) 115 N Centre St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds.

In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: German Lutheran — DATE OF BURIAL: Oct 25, 1915

20 UNDERTAKER: Louis Stein — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinama, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

17072

(104)

Registration Dist. No. 7

[1] PLACE OF DEATH

County Allegany

Village or City Lonaconing (No. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

[2] FULL NAME Gilbert Stevenson

PERSONAL AND STATISTICAL PARTICULARS

[3] SEX	[4] COLOR OR RACE	[5] SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	Single

[6] DATE OF BIRTH Sept 11th, 1915
(Month) (Day) (Year)

[7] AGE ..... yrs. 1 mos. 19 ds. If LESS than 1 day, ... hrs. OR ..... min.?

[8] OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

[9] BIRTHPLACE (State or country) Maryland

PARENTS

[10] NAME OF FATHER Albert Stevenson

[11] BIRTHPLACE OF FATHER (State or country) Maryland

[12] MAIDEN NAME OF MOTHER Flora McFarland

[13] BIRTHPLACE OF MOTHER (State or country) Maryland

[14] THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Stevenson

(Address) Lonaconing, Md

[15] Filed Oct 31, 1915 J. O. Bullock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

[16] DATE OF DEATH Oct 31st, 1915
(Month) (Day) (Year)

[17] I HEREBY CERTIFY, That I attended deceased from Oct 26, 1915, to Oct 30, 1915, that I last saw h... alive on Oct 30th, 1915, and that death occurred on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry ... Hodges, M. D.

Oct 31st, 1915 (Address) Lonaconing Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

[18] LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

[19] PLACE OF BURIAL OR REMOVAL Old Cemetery — DATE OF BURIAL Nov 1, 1915

[20] UNDERTAKER Asher & Co — ADDRESS Lonaconing

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner;* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma." "Convulsions." "Debility" ("Congenital." "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

17073

(113)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH
County Allegany
Village or City Cumberland (No. 50 Wineow St.; Ward)

2 FULL NAME Ella Stewart

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: March 13 (Month) (Day), 1883 (Year)

7 AGE: 31 yrs. 11 mos. 7 ds.
If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer): Home

9 BIRTHPLACE (State or country): Md

PARENTS
10 NAME OF FATHER: Geo. M. Stewart
11 BIRTHPLACE OF FATHER (State or country): W. Va.
12 MAIDEN NAME OF MOTHER: Mary Johnson
13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ollie Goss
(Address) 50 Wineow St.

15 Filed OCT 21 1915, 191
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 20th (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from August, 1915, to Oct 20th, 1915, that I last saw h[illegible] alive on Oct. 1st, 1915, and that death occurred on the date stated above, at 9 A. m.

The CAUSE OF DEATH * was as follows: Chronic Nephritis

(Duration) 2 yrs. mos. ds.

Contributory Secondary: Anaemia

(Duration) yrs 3 mos. ds.

(Signed) John R. Finnifrock M. D.
Oct 21 1915 (Address) Cumberland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Patrick Cemetery
DATE OF BURIAL: Oct 22, 1915

20 UNDERTAKER: Jerry Stein
ADDRESS: Cumberland

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

MARGIN RESERVED FOR BINDING

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STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

17074

(9)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Frostburg (No. ..... Blair St.; ..... Ward)

2 FULL NAME John Street

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June (Month) 18 (Day), 1912 (Year)

7 AGE: 3 yrs. 3 mos. 23 ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Elias Street

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rose Habrehair

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eli Street

(Address) Frostburg Md

15 Filed Oct 12, 1915 D. F. L. Conroy
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 11 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10-11-, 1915, to 10-11-, 1915, that I last saw h[illegible] alive on 10-11-, 1915, and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory Child sick 6 days

Secondary Never seen by physician

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Street, M. D.

10/12, 1915 (Address) Frostburg, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Allegany Cem. DATE OF BURIAL: 10/12, 1915

20 UNDERTAKER: [illegible] Furniture & Undertaking Co. ADDRESS: Frostburg Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

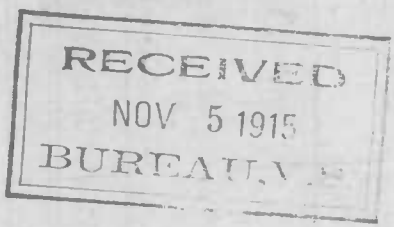
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, perilonacum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be careful'y supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

17075

64

Registration Dist. No. VII

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegheny

Village or City Mc Cool. (No. ....., ... St.; ..... Ward)

2 FULL NAME Susan Tharp

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ (Write the word): Widowed

6 DATE OF BIRTH: July (Month) 29 (Day) 1832 (Year)

7 AGE: 83 yrs. 2 mos. 5 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Virginia

PARENTS

10 NAME OF FATHER: Samuel Ruckman

11 BIRTHPLACE OF FATHER (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Ruckman

13 BIRTHPLACE OF MOTHER (State or country): Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles E. Tharp

(Address) Keyser, W.Va.

15 Filed 10/7/1915 W M Caldwell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 4 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July, 1915, to Oct 1, 1915, that I last saw her alive on Oct 1st, 1915, and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH * was as follows: Cerebral Apoplexy

(Duration) 3 yrs. ..... mos. ..... da.

Contributory Secondary .....

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) W M Baer, M. D.

Oct. 6, 1915 (Address) Keyser W.Va.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... da. In the State, ... yrs. ..... mos. ..... da.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Dayton's Cemetery — DATE OF BURIAL: 10/6, 1915

20 UNDERTAKER: J. H. Markwood Sons — ADDRESS: Keyser, W. Va

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

17076

120

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. West md. Ho. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Perry M Thompson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH: October — (Month) (Day), 1868 (Year)

7 AGE: 47 yrs. — mos. — ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Sawyer
(b) General nature of industry business, or establishment in which employed (or employer): Saw Mill

9 BIRTHPLACE (State or country): W. Va.

PARENTS

10 NAME OF FATHER: A. J. Thompson

11 BIRTHPLACE OF FATHER (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Ossie England

13 BIRTHPLACE OF MOTHER (State or country): W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Guy Taylor

(Address) Elkins W. Va.

15 Filed Oct 23, 1915 Max Sutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October (Month) 23 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1915, to Oct 23, 1915, that I last saw him alive on Oct 23, 1915, and that death occurred on the date stated above, at 3 P m.

The CAUSE OF DEATH * was as follows:

Uraemia

(Duration) yrs. mos. 3 ds.

Contributory / Secondary Chronic Interstitial Nephritis

(Duration) 2 yrs. — mos. — ds.

(Signed) D. W. A. Main, M. D.

Oct 23, 1915 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 2 ds. In the State, yrs. mos. 2 ds.

Where was disease contracted, if not at place of death? Durbin W. Va.

Former or usual residence Used routine Durbin W. Va.

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Elkins W Va	Oct 24, 1915

20 UNDERTAKER	ADDRESS
Louis Sons	City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

1 PLACE OF DEATH

17077

(5)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

County Allegany

Village or City Cumberland (No. County Home St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME ~~Sheldon~~ Thompson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
?	White	Single

6 DATE OF BIRTH Oct 3rd (Month) (Day) 1915 (Year)

7 AGE ... yrs. ... mos. ... ds. | If LESS than 1 day, ... hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER Alban Thompson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Orth

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John R Trimpfield

(Address) Cumberland

15 Filed OCT 4 1915 — Max Gus Elm REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 3rd (Month) (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1915, to Oct 3rd, 1915, that I last ~~saw him~~ alive on ..., 191..., and that death occurred on the date stated above, at 12:40 p m.

The CAUSE OF DEATH * was as follows:

Prematurity of birth

(Duration) ... yrs. ... mos. ... ds.

Contributory
Secondary

(Duration) ... yrs. ... mos. ... ds.

(Signed) John R Trimpfield, M. D.

Oct 4, 1915 (Address) Cumberland

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cremation	Oct 4, 1915

20 UNDERTAKER	ADDRESS
Alban Thompson	City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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STATE OF MARYLAND
CERTIFICATE OF DEATH

17078

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH
County Allegany
Village or City Cumberland (No. Allegany Hse St.; Ward)

2 FULL NAME Robert Trent

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Unknown (Month) (Day), 1857 (Year)

7 AGE: About 63 yrs. — mos. — ds.
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Restaurant Keeper
(b) General nature of industry business, or establishment in which employed (or employer): Restaurant.

9 BIRTHPLACE (State or country): Va.

PARENTS

10 NAME OF FATHER: Thomas Trent
11 BIRTHPLACE OF FATHER (State or country): Va.
12 MAIDEN NAME OF MOTHER: Mat Kasw
13 BIRTHPLACE OF MOTHER (State or country): Mat Kasw

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Robt. Trent
(Address) 57 Glenn St.

15 Filed Oct 10, 1915 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 6th (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4th, 1915, to Oct 6th, 1915, that I last saw him alive on Oct 6th, 1915, and that death occurred on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH * was as follows:

Cancer of the Liver

(Duration) yrs. 6 mos. ds.

Contributory / Secondary: Shock following

operation (Duration) yrs. mos. 3 ds.

(Signed) Jurgen Harris, M. D.

Oct 9th 1915 (Address) Cumberland Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. 3½ ds.
In the State, Unknown yrs. mos. ds.
Where was disease contracted, if not at place of death? Cumberland, Md.
Former or usual residence 57 Glenn St.

19 PLACE OF BURIAL OR REMOVAL: Summer Leas
DATE OF BURIAL: Oct. 10, 1915

20 UNDERTAKER: Louis Stein
ADDRESS: Cumberland, Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 8

17079

9

[1] PLACE OF DEATH

County Allegany

Village or City Lonaconing, (No. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

[2] FULL NAME Catherine Upnutt

PERSONAL AND STATISTICAL PARTICULARS

[3] SEX: Female

[4] COLOR OR RACE: White

[5] SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

[6] DATE OF BIRTH: May 9th, 1912 (Month) (Day) (Year)

[7] AGE: 3 yrs. 5 mos. 5 ds. If LESS than 1 day, ... hrs. OR ..... min. ?

[8] OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): —

[9] BIRTHPLACE (State or country): Lonaconing Md

PARENTS

[10] NAME OF FATHER: Jas. P. Upnutt

[11] BIRTHPLACE OF FATHER (State or country): Scotland

[12] MAIDEN NAME OF MOTHER: Bessie McKenzie

[13] BIRTHPLACE OF MOTHER (State or country): Pennsylvania

[14] THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Bessie Upnutt
(Address) Lonaconing,

[15] Filed Oct 15, 1915 J. O. Gullett Registrar

MEDICAL CERTIFICATE OF DEATH

[16] DATE OF DEATH: Oct 14th, 1915 (Month) (Day) (Year)

[17] I HEREBY CERTIFY, That I attended deceased from Oct 11, 1915 to Oct 14th, 1915, that I last saw her alive on Oct 14th, 1915, and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Gullett, M. D.

Oct 14th, 1915 (Address) Lonaconing,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

[18] LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds
Where was disease contracted, if not at place of death?
Former or usual residence

[19] PLACE OF BURIAL OR REMOVAL: Laurel Hill Cemetery — DATE OF BURIAL: Oct 15, 1915

[20] UNDERTAKER: M. Eichhorn — ADDRESS: Lonaconing

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

17080

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 7

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Moscow Mills (No. ..... St.; ..... Ward)

2 FULL NAME John M. Trumbull

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): Single

6 DATE OF BIRTH: Aug 15th, 1913 (Month) (Day) (Year)

7 AGE: 2 yrs. 2 mos. 5 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Moscow Mills, Maryland

PARENTS

10 NAME OF FATHER: Robt Trumbull

11 BIRTHPLACE OF FATHER (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Florence Murphy

13 BIRTHPLACE OF MOTHER (State or country): U.S.A.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Robt Trumbull

(Address) Moscow Mills Md

15 Filed Oct 19, 1915 S. A. Boucher, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 20th, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 13th, 1915, to Oct 20th, 1915; that I last saw him alive on Oct 19th, 1915; and that death occurred on the date stated above, at 1-15 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory
Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. D. Skilling, M. D.

Oct 20th, 1915 (Address) Lonaconing

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Hill Cemetery — DATE OF BURIAL: Oct 21st, 1915

20 UNDERTAKER: M. Eichhorn — ADDRESS: Lonaconing

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH — 17081

County Allegany

Village or City Cumberland (No. 70, Ann St. St.; Ward)

2 FULL NAME Jacob Albert Valentine

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June 6, 1848 (Month) (Day) (Year)

7 AGE: 67 yrs. 4 mos. 8 ds. | If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): B & O. R.R.Co.

9 BIRTHPLACE (State or country): Pa

PARENTS

10 NAME OF FATHER: Benjamin Valentine

11 BIRTHPLACE OF FATHER (State or country): Pa

12 MAIDEN NAME OF MOTHER: Sarah Hite

13 BIRTHPLACE OF MOTHER (State or country): Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E Valentine
(Address) 70 Ann St.

15 Filed OCT 15 1915, 191 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 14, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct., 1910, to Oct. 14, 1915, that I last saw h[illegible] alive on Oct 14, 1915, and that death occurred on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH * was as follows:
Tuberculosis of bowel
(Duration) 5 yrs. 0 mos. 14 ds.

Contributory Secondary: Tuberculosis of lungs
(Duration) 1 yrs. 0 mos. 2 ds.

(Signed) J. M. Spear, M. D.
Oct 14, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ...yrs. ...mos. ...ds. In the State, ...yrs. ...mos. ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Rose Hill | DATE OF BURIAL: Oct 17, 1915

20 UNDERTAKER: Jones Stein | ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

17082

(19)

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. 240, Centre St.; Ward)

2 FULL NAME Ursula A. Walters

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: June 19, 1835 (Month) (Day) (Year)

7 AGE: 80 yrs. 3 mos. 19 ds.

If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: X at Home
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Va

PARENTS

10 NAME OF FATHER: Broderick Walters

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Carder

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Walters

(Address) Cumberland

15 Filed OCT 9 1915 M. Sutton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 8, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1915, to Sept 22, 1915; that I last saw h alive on Sept 22, 1915, and that death occurred on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH * was as follows:

Chr. Endocarditis

(Duration) 1 yrs. — mos. — ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Geo. H. Faulkner, M. D.

Oct 9, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Rose Hill

DATE OF BURIAL: OCT 10, 1915

20 UNDERTAKER: J. C. Wolford

ADDRESS: Cumberland

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningcs, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

17083

(67)

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. 39, Judge St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charles Weiskittle

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Aug (Month) 14 (Day), 1836 (Year)

7 AGE: 79 yrs. 2 mos. 1 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Machenist
(b) General nature of industry business, or establishment in which employed (or employer):

311

9 BIRTHPLACE (State or country): Pa

PARENTS

10 NAME OF FATHER: August Weiskittle

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Stroutman

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Chas. Weiskittle

(Address) 39 Judge St

15 Filed OCT 18 1915 191 Mat Cotton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 15 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1915, to Oct 15, 1915; that I last saw him alive on Oct 14, 1915; and that death occurred on the date stated above, at 7 P.m.

The CAUSE OF DEATH * was as follows:

General Paresis

(Duration) 2 yrs. mos. ds.

Contributory Secondary None.

(Duration) yrs. mos. ds.

(Signed) J. H. Weber, M. D.

Oct 17 191 5 (Address) Ambulance Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death ?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: German Lutheran Cty — DATE OF BURIAL: Oct 18, 1915

20 UNDERTAKER: Louis Stein — ADDRESS: Ennis Ave.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

[1] PLACE OF DEATH 17084

County Allegany

Registration Dist. No. 9

Village or City Frostburg (No. [illegible], New Hope Rd St.; [illegible] Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

[2] FULL NAME Child Welch

PERSONAL AND STATISTICAL PARTICULARS

[3] SEX: M | [4] COLOR OR RACE: W | [5] SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word): Single

[6] DATE OF BIRTH: 10 (Month) 13 (Day) 1914 (Year)

[7] AGE: Still born ____ yrs. ____ mos. ____ ds. | If LESS than 1 day, ____ hrs. OR ____ min. ?

[8] OCCUPATION
(a) Trade, profession, or particular kind of work: [illegible]
(b) General nature of industry, business, or establishment in which employed (or employer): —

[9] BIRTHPLACE (State or country): Md

PARENTS

[10] NAME OF FATHER: Robt Welch

[11] BIRTHPLACE OF FATHER (State or country): Md

[12] MAIDEN NAME OF MOTHER: Jennie Uptegrove

[13] BIRTHPLACE OF MOTHER (State or country): Md

[14] THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Robt Welch

(Address) Frostburg Md

[15] Filed Oct 19, 1914 Wm. L. Conway Registrar

MEDICAL CERTIFICATE OF DEATH

[16] DATE OF DEATH: 10 (Month) 13 (Day), 1914 (Year)

[17] I HEREBY CERTIFY, That I attended deceased from [illegible], 191[illegible], to [illegible], 191[illegible],

that I last saw h[illegible] alive on [illegible], 191[illegible]

and that death occurred on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Dr C L Conway, M. D.

Oct 14th, 1914 (Address) Frostburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

[18] LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

[19] PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ____, 191[illegible]

[20] UNDERTAKER | ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

1 PLACE OF DEATH 17085

County Cumberland

Village or City Allegany (No. Apple Alley St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Winterroth

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Dec (Month) 15 (Day), 1879 (Year)

7 AGE: 35 yrs. 10 mos. 14 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Glass Worker
(b) General nature of industry business, or establishment in which employed (or employer): Glass Factory

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Louis Winterroth

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie E. Kneebner

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis Winterroth
(Address) Cumbd Md

15 Filed NOV 1 1915, 191 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Oct. (Month) 29 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1915, to Aug 30, 1915, that I last saw him alive on Aug 30, 1915, and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

From History Several (Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) F. W. Forkbrasser, M. D.

Oct 31, 1915 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Nov 1, 1915

20 UNDERTAKER: Louis Stein — ADDRESS: Cumbd

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

17086

(3)

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. 68, Paca St.; Ward)

2 FULL NAME Stillborn Winters

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
?	White	Single

6 DATE OF BIRTH Oct 1, 1915 (Month) (Day) (Year)

7 AGE ... yrs. ... mos. ... ds. | If LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER George Winters

11 BIRTHPLACE OF FATHER (State or country) Cumberland, Md

12 MAIDEN NAME OF MOTHER Mazie Grey

13 BIRTHPLACE OF MOTHER (State or country) Shipstacks Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. H. Trevaskis

(Address) Cumberland Md

15 Filed OCT 2 1915, 191 Max Hilton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 1, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..., 191..., to ..., 191...,

that I last saw h... dead ~~alive~~ on Oct 1, 1915

and that death occurred on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Stillbirth

(Duration) ... yrs. 3 mos. ... ds.

Contributory
Secondary

(Duration) ... yrs. ... mos. ... ds.

(Signed) R. H. Trevaskis, M. D.

Oct 1, 1915 (Address) Cumberland md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cremation	Oct 2, 1915
20 UNDERTAKER Father	ADDRESS
George Winters	Cumberland

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meningcs, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 11

17087

(153)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or City Vale Summit (No. ____, ____ St.; ____ Ward)

2 FULL NAME Baby Winters

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: October 6th, 1915 (Month) (Day) (Year)

7 AGE: ____ yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. OR 10 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Jacob A Winters

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lucy Blanche Wilson

13 BIRTHPLACE OF MOTHER (State or country): Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob A Winters

(Address) Vale Summit Md

15

Filed ____, 191____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 6th, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1915, to Oct 6th, 1915, that I last saw h[er] alive on Oct 6th, 1915 and that death occurred on the date stated above, at 5:40a m.

The CAUSE OF DEATH* was as follows:

congenital atelectasis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary: Forceps presentation - Prolonged labor - contracted pelvis on part of mother.

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Wm Michael, M. D.

Oct 6th, 1915 (Address) Frostburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Vale Summit Md

DATE OF BURIAL: 10/6, 1915

20 UNDERTAKER: Father

ADDRESS: Vale Summit Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the busiuess or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupatiou has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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17088

169 ~~169~~

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Village or ~~City~~ Cumberland (No. B & O Ry Co Ash Pit St.; 6 Ward)

2 FULL NAME Joe Wroe

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Don't know

6 DATE OF BIRTH ~~Dec~~ (Month) ~~17~~ (Day), 1870 (Year)

7 AGE ~~45~~ yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer) B & O Ry Co

9 BIRTHPLACE (State or country) Poland Russia

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (State or country) Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. H. Dutton

(Address) 229 N. Centre St.

15 Filed OCT 19 1915, 191 Max Linton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 15 (Month) (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ~~Dec~~, 191~~4~~, to ~~Dec~~, 191~~5~~, that I last saw h~~im~~ alive on ~~Dec~~, 191~~5~~, and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH * was as follows:

Drowned - Accidental
Drowned in Ash Pit

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Wm. H. Shaw Coroner, M. D.

Oct 16 1915 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Peters Cem

DATE OF BURIAL Oct 18, 1915

20 UNDERTAKER H. H. Dutton

ADDRESS City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied: AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

17089

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

1 PLACE OF DEATH

County Allegany

Village or City Cumberland (No. 278, N. Centre St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elleanor Gimmella

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Unknown	White	Single

6 DATE OF BIRTH: Oct (Month) 18 (Day), 1915 (Year)

7 AGE: ... yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. OR ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Carl Gimmella

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Rose Sahlund

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr J. H. Wilson

(Address) Cumberland Md

15 Filed Oct 20, 1915 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 18 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1915, to Oct 18, 1915, that I last saw ~~him~~ it alive on Oct 18, 1915, and that death occurred on the date stated above, at 8 A. m.

The CAUSE OF DEATH * was as follows:

Mortis

(Duration) ... yrs. ... mos. ... ds.

Contributory
Secondary

(Duration) ... yrs. ... mos. ... ds.

(Signed) J H Wilson, M. D.

Oct 20, 1915 (Address) Cumberland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cemetery	Oct 20, 1915

20 UNDERTAKER	ADDRESS
Carl Gimmella	City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sorcoma,* etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemio,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

17090

(64)

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Allegany

Outside of City Limits.

near Village or City Cumberland (No. Lintuersville Md St.; Ward)

2 FULL NAME Alice Zimmerly

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June (Month) 14 (Day), 1845 (Year)

7 AGE: 70 yrs. 4 mos. 13 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer): at Home

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Samuel Zimmerly

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sarah Hartsock

13 BIRTHPLACE OF MOTHER (State or country): Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marchia Zimmerly

(Address) Lintuersville Md

15 Filed Oct 29, 1915 Mac Fiske Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 28 (Day), 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1915, to Oct 28, 1915, that I last saw h alive on Oct 27, 1915, and that death occurred on the date stated above, at 1 a.m.

The CAUSE OF DEATH * was as follows:

Arterio - sclerosis

(Duration) yrs. mos. ds.

Contributory / Secondary: Cerebral Hemorrhage

(Duration) yrs. mos. 5 ds.

(Signed) F. M. Wilson M. D.

Oct 28, 1915 (Address) Cumberland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cem — DATE OF BURIAL: Oct 30, 1915

20 UNDERTAKER: Louis Stein — ADDRESS: City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Corcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.